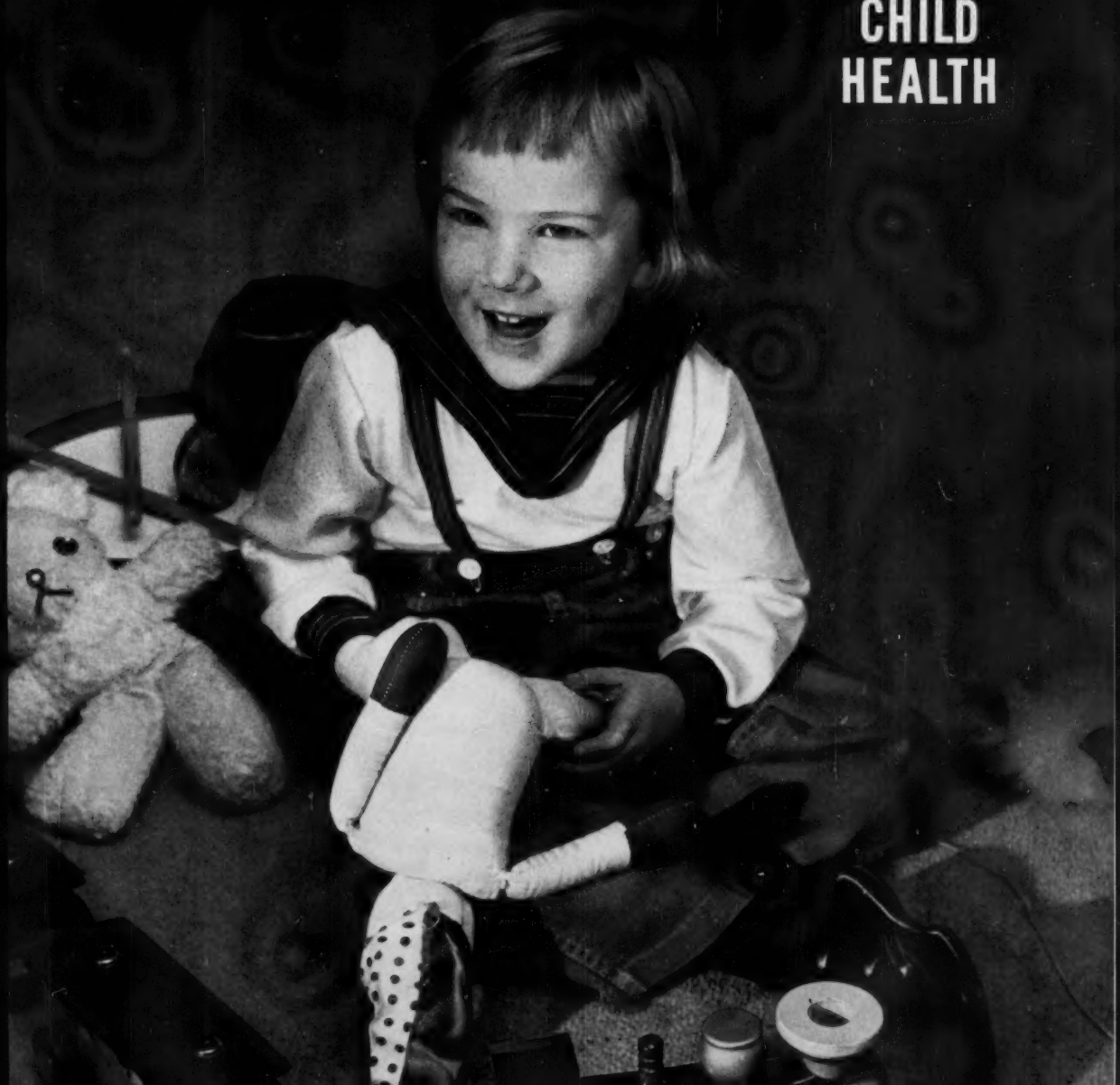
March, 1957
Volume 56
Number 3

Journal

of the Michigan State Medical Society

CHILD HEALTH



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(1) Finland, M.: *J.A.M.A.* 158:188, 1955. (2) Kirby, W. M. M.; Hudson, D. G., & Noyes, W. D.: *Arch. Int. Med.* 98:1, 1956. (3) Wise, R. I.; Cranny, C., & Spink, W. W.: *Am. J. Med.* 20:176, 1956. (4) Rantz, L. A., & Rantz, H. H.: *Arch. Int. Med.* 97:694, 1956. (5) Kempe, C. H.: *California Med.* 84:242, 1956. (6) Spink, W. W.: *Ann. New York Acad. Sc.* 65:175, 1956. (7) Felix, N. S.: *Pediat. Clin. North America* 3:317, 1956. (8) Altemeier, W. A.; Culbertson, W. R.; Sherman, R.; Cole, W.; Elstun, W., & Fultz, C. T.: *J.A.M.A.* 157:305, 1955. (9) Weil, A. J., & Stempel, B.: *Antibiotic Med.* 1:319, 1955. (10) Jones, C. P.; Carter, B.; Thomas, W. L., & Creadick, R. N.: *Obst. & Gynec.* 5:365, 1955. (11) Perry, R. E., Jr.: *North Carolina M. J.* 16:567, 1955. (12) Horton, B. F., & Knight, V.: *J. Tennessee M. A.* 48:367, 1955.

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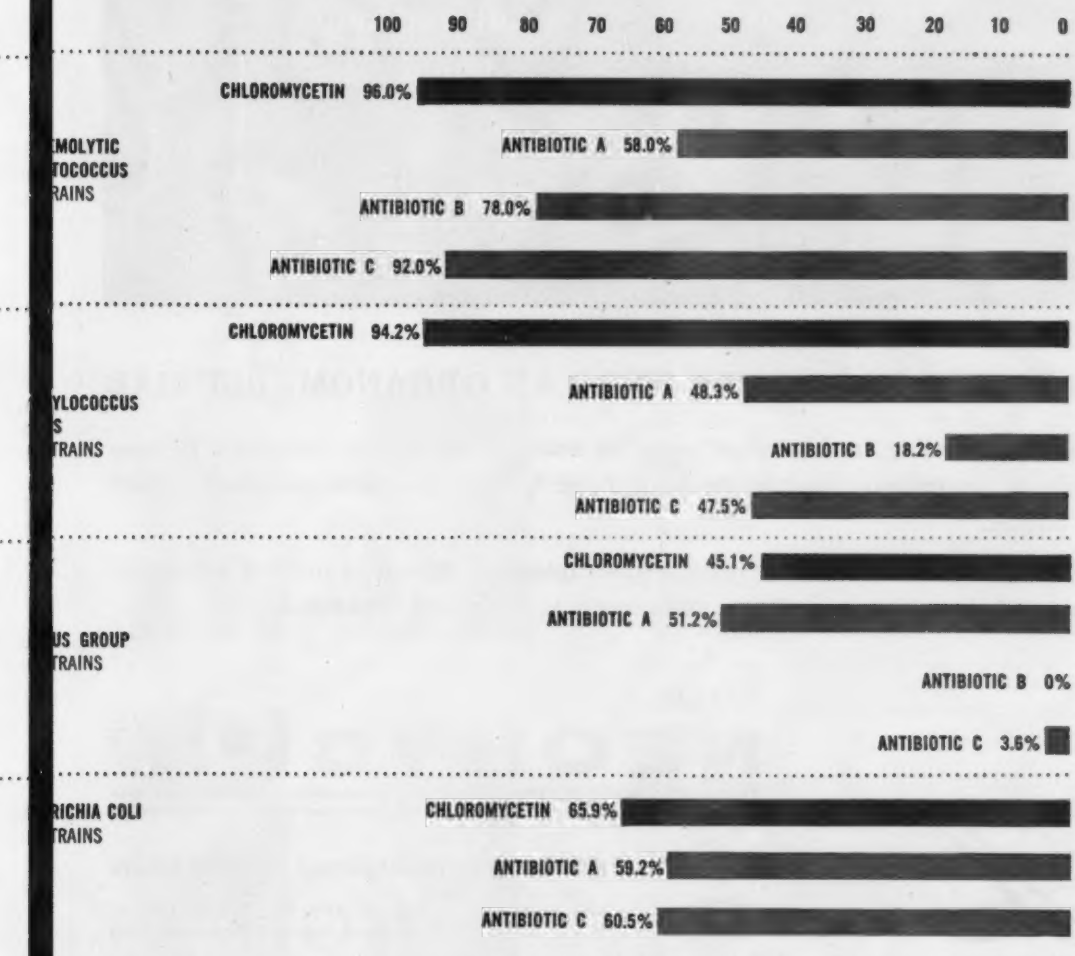

*This graph is adapted from Rantz and Rantz.[4] It is based on *in vitro* studies of bacteria freshly isolated from clinical materials.

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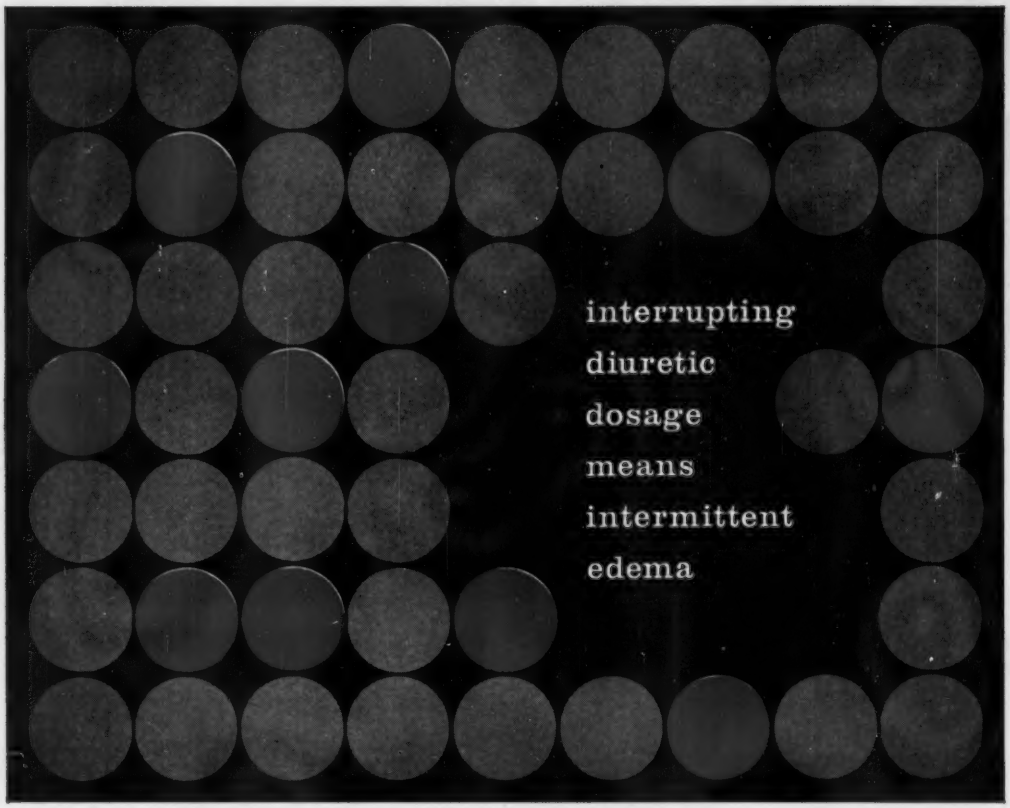

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Published monthly by the Michigan State Medical Society as its official journal at 2642 University Avenue, Saint Paul 14, Minnesota.

Entered at the post office at Saint Paul, Minnesota, as second class matter, May 7, 1930, under the Act of March 3, 1879.

Acceptance for mailing at special rate of postage provided for in Section 1103 Act of October 3, 1917, authorized August 7, 1918.

Yearly subscription rate, $6.00; single copies, 60 cents. Additional postage; Canada, $1.00 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year.

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Lankenau Hospital in Philadelphia has announced plans for a $40,000,000 building project, the building of the most completely integrated medical center. The hospital of the future will divide its attention and resources almost equally between treating the sick in its great hospital facilities and preventive medicine and clinical instruction. Lankanau claims to be the only hospital in the United States with a comprehensive public health education program for preventive medicine; with an unusual health museum and auditorium attracting 40,000 visitors annually. These include medical and other professional groups, educational films; lectures and open forums on medical topics.

U. S. COMMISSION ON AGING PROPOSED

Senator Potter of Michigan has introduced a bill (S258) to set up a U. S. Commission on Aging, ten members from the Senate and House, the executive branch and the public. It will study aged persons' problems employment, income maintainance, health and physical care, housing living arrangements and recreation. The commission's recommendations are to be made to Congress before July 1, 1958, at which time the commission automatically dissolves.

CARE FOR AGED COSTLY

"Unless more economical and effective methods are found and widely applied, the growing population of elderly persons and disabled people of all ages requiring prolonged (medical and hospital) care will continue to bankrupt themselves, and ultimately bankrupt many local governments and voluntary health insurance plans," Dr. LeRoy E. Burney, surgeon general of the U. S. Public Health Service, declared at the University of Michigan, on January 23, 1957, speaking to local health department officials at the first Institute on Public Health Administration conducted by the U-M School of Public Health and the Michigan Department of Health.

SCHERING AWARD CHEMOTHERAPY OF MENTAL ILLNESS

New areas of research opened up by the development of the tranquilizing drugs have had a marked impact on the interest of the doctors of tomorrow, according to Dr. R. Richard McCormick, Chairman of the Committee on the Schering Award.

The Schering Award is an annual competition among medical students in the United States and Canada, with prize-winning papers being given national recognition. The competition has been sponsored by Schering Corporation, pharmaceutical manufacturers of Bloomfield, N. J., annually since 1939. Dr. McCormick reported that medical students submitting papers for the pharmaceutical manufacturing firm's annual competition have shown a clear preference for the topic, "Recent Advances in the Biochemical Aspects and Treatment of Mental Disease." To date, the papers dealing with this subject are almost double those submitted on both cardiology and eye disorders, the other two subjects for the 1957 competition.

Dr. McCormick attributed the growing interest of medical students in this topic to the recent flood of publicity about tranquilizing agents, and about the problem of mental illness.

He announced that the deadline date for entry forms for the contest has been extended to March 15, 1957, but warned that all manuscripts must be submitted by June 30, 1957.

Cash awards have been doubled to $4,500 this year, he added, bringing the first prize in each of the three categories to $1,000, and the second prize in each to $500. Other outstanding papers will be awarded professionally useful gifts.

The contest is open to all medical students in the United States and Canada. Information may be obtained by writing the Schering Award Committee, 60 Orange Street, Bloomfield, N. J.

DIABETES HISTORY

In 1947, through the efforts of Dr. Elliott P. Joslin, The Diabetic Fund was created. One of its functions was to supervise the awarding of the Quarter Century Victory Medal, to those diabetics who have been controlled on a diet and insulin for twenty-five years without developing any complications. The idea behind the creation was twofold, first, "to encourage diabetic patients to persevere in the careful control of their disease by proving through living examples that such control was worth while," and secondly, "to learn from those who earned the award the methods they had followed to attain it."

Up to September 1956 only sixty-eight such medals had been given out, including one to a diabetic in Ann Arbor. To meet the requirements the patient's condition must be excellent, as shown by a complete physical examination. An accredited ophthalmologist must certify that the eyes are free from complications. X-rays of the

(Continued on Page 312)

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1. Locket, S.: Brit. M.J. *1*:809 (Apr. 2) 1955.

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2. Wright, W.T., Jr., et al.: J. Kansas M. Soc. *57*:410 (July) 1956.

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Riker LOS ANGELES

Heart Beats

THE RESEARCH PROGRAM OF THE AMERICAN HEART ASSOCIATION, ITS AFFILIATES AND CHAPTERS

CHARLES D. MARPLE, M.D., *Medical Director*

The necessity for expanding the scientific research effort of the nation is clearly evident and generally understood, but public recognition of this fact is of relatively recent origin.

Industry has provided much of the impetus to the twentieth century renaissance of research. No literate adult can fail to note the regular appearance in the press of advertisements by which industry solicits the services of men with scientific training and skills, and entices the youth of our country into scientific careers—for industry's sake. For the most part, these appeals have been made to recruit men in the physical sciences: engineering, physics and electronics. Recently, the pressing need for biological scientists has been emphasized, principally by educators and the scientists themselves. It is now obvious that what America needs most is not the traditional "good five-cent cigar," but more high-grade scientific manpower.

Since World War II, both Federal and private agencies have instituted programs of research support in a wide variety of scientific fields, physical, biological and sociological. While these programs have much in common, each has its own individuality. Several organizations, including the Life Insurance Medical Research Fund, the National Heart Institute of the National Institutes of Health, and the American Heart Association, are concerned primarily with the cardiovascular field.

The growth of the American Heart Association's program of research support has been dramatic. The first awards were made in 1948, and the first appointees began their work under Association auspices during the fiscal year, 1949-1950. In that year, there were twenty-four Research Fellows, two Established Investigators, and nineteen Grants-in-aid; no Career Investigators were appointed at that time. The total amount of money invested by the Association in research during the year was $222,433.

Today, in the eighth year of the program, there are sixty Research Fellows, sixty-four Established Investigators, and 180 Grants-in-aid; in addition, three Career Investigators have been selected for lifelong support by the Association. The total sum invested in research during the year exceeds $1,850,000. The day when the staff could be personally familiar with the life story of each investigator—in effect, know "the name, number and batting average of each player," is now but a memory.

In numbers of individuals supported and in amounts of money spent, the research program of the Association is unquestionably successful. But what of its quality, which, in the final analysis, is the most vital consideration?

The research program of the American Heart Association rests upon two fundamental concepts: (1) that support should be given to individual investigators rather than to projects *per se*, and (2) that the research activities selected for support should cover a wide range of scientific disciplines, with emphasis on basic research.

Accordingly, through the Research Fellowship, the Association attempts to attract promising young scientists, provide them with an opportunity of obtaining training and experience, of developing the necessary knowledge and skills, and of acquiring the spirit of dedication which is essential to the maximum productivity in investigation. The Established Investigatorship goes a step further and gives the scientist an opportunity to establish himself as an independent worker. There is no waste in this program. The tyro who leaves research for academic medicine or for clinical practice is the better physician for his research experience. For the exceptional individual, there is the possibility of lifelong support as a Career Investigator, a unique opportunity which reflects the vision of the Association's early leadership.

No one can foretell where the next important scientific discovery will be made; no one can guess what esoteric research will lead to a practical cardiovascular advance. What we do know is that basic studies in physiology, chemistry and physics produce fundamental knowledge from which come all practical medical developments. It is only by pursuing every possible hypothesis that significant discoveries are brought to fruition.

This attitude has permitted wide latitude in the types of investigation supported. Much of this work relates directly to arteriosclerosis, hyperten-

(Continued on Page 282)

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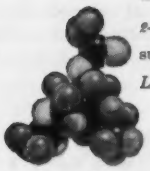

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RESEARCH PROGRAM

(Continued from Page 280)

sion, rheumatic fever and other specific cardiovascular conditions, but, on the other hand, many research projects are selected which can only be classified as basic physiology, chemistry and biology.

As the national program has grown, the increase in the number of applications submitted and in the total funds requested each year has kept pace with the increase in available funds. A certain loss of flexibility has ensued as a natural consequence of this growth. Of the many proposals made for introducing new forms of research support, only a few can be adopted. Artificial limitations are imposed by necessity, on the types of awards offered, on the sums awarded, and on the length of time for which awards are made.

Affiliates and Their Chapters

The growth of the affiliated heart associations and their chapters has provided an unexcelled opportunity for diversification of research support. Although these local heart associations are bound by the general research policies of the national organization, they are in most respects free to spend their funds as they deem advisable. As funds for research have increased on the local level, from a nation-wide total of $477,500 in 1949 to more than $2,900,000 in 1956, heart associations have been enabled to support research in more effective ways. They have instituted forms of research support hitherto not offered by the national agencies, e.g., chairs of cardiovascular teaching and research, student fellowships, block and fluid grants, and so forth.

Here, then, is a highly imaginative and practically unrestricted research program which has utilized national and local resources to support a broad spectrum of scientific research in a variety of ways, designed in many instances to fit a particular need. As more funds are collected, additional investigators and projects can be supported and additional types of assistance can be offered to meet the demands of the everchanging research picture. An evaluation of these programs will demonstrate eventually the merit in each individual approach.

The essential point, however, is that a program of research support, like any other scientific endeavor, requires vision, imagination, specialized knowledge and good judgment. It is necessarily experimental, but in creating new frontiers of knowledge, there is a high degree of promise and satisfaction.

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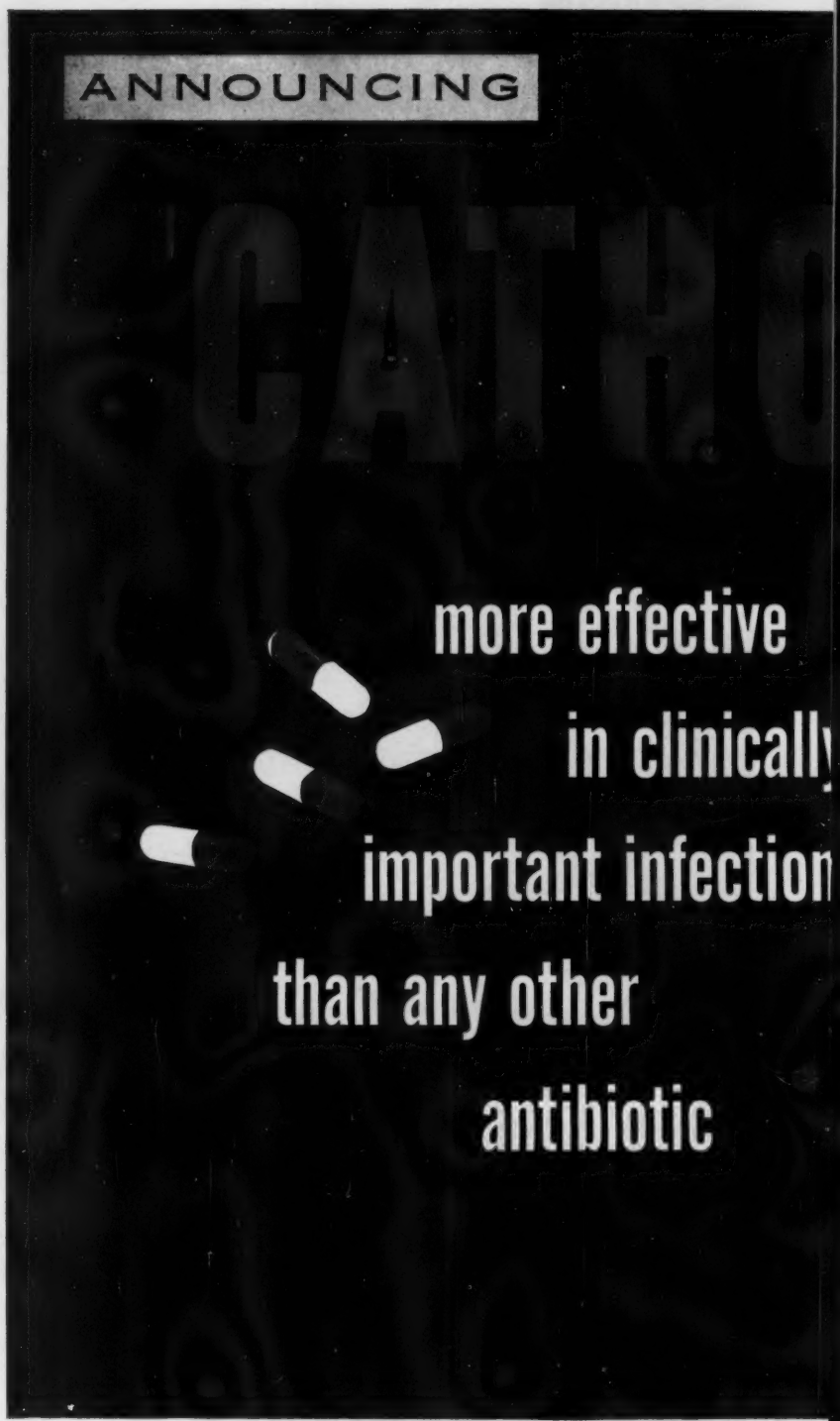

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COMPARE THESE ADVANTAGES:

1. Proved effectiveness in the largest number of clinically important infections including those caused by antibiotic-resistant *staphylococci* and proteus.
2. Therapeutic, *bactericidal* blood levels are promptly achieved.
3. Exceptionally well tolerated; patient sensitivity reactions are rare at recommended dosage.
4. No yeast or fungal super-infections nor any antibiotic-induced enteritis, vaginitis or proctitis have been reported following CATHOCILLIN.
5. No problems of cross-resistance have been encountered with CATHOCILLIN.
6. The normal intestinal flora is not disturbed by CATHOCILLIN.

DOSAGE: *for adults—two capsules q.i.d.; for children under 100 lbs.—dosage in proportion to weight (e.g. one capsule q.i.d. for a child weighing 50 lbs.).*

CONSIDER CATHOCILLIN FIRST

—for these clinically important infections: tonsillitis; pharyngitis; pneumonia; otitis media; cervical lymphadenitis; streptococcal sore throat; infected tooth sockets; Vincent's infection; acne and superficial skin infections; impetigo; boils, furuncles and carbuncles; lung abscess; bronchitis; mastitis; osteomyelitis; wound infections; postoperative wound infections and infected lacerations; staphylococcal enteritis, staphylococcal diarrhea of the newborn; peritonitis (caused by susceptible organisms); pelvic inflammatory disease; gonorrhea; gonococcal arthritis; urethritis; scarlet fever; erysipelas.

SUPPLIED: *Blue and white capsules of* 'CATHOCILLIN' *—each containing 125 mg. of* 'CATHOMYCIN' *(as Sodium Novobiocin, Merck) and 75 mg. (125,000 units) Potassium Penicillin G; bottles of 16.*

In one prescription the one antibiotic product most likely to be effective

MSD

MERCK SHARP & DOHME
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AMA Washington Letter

THE MONTH IN WASHINGTON

With Congress now well along in its session, the list of health and medical bills totals several hundred. Some are minor—and few persons will be affected regardless what happens. Others just don't make much sense—and the committees, regardless of politics, can be trusted to let these measures die a peaceful death.

But there are scores of others—all important bills—that have some chance of passage, their prospects ranging from an outside possibility to a strong probability. At this stage they can be regarded as the raw material out of which will come the studies, the debates and the arguments in the months ahead.

One of the major health-medical issues is federal aid to medical, dental and osteopathy schools. On this the administration wants grants for construction and equipment only; some of the Democrats want to include money for operating expenses as well.

In number of bills introduced, the general subject of problems of the aging probably tops the list. And that is no surprise. For several years welfare workers, housing experts and recreational leaders, as well as physicians, have been looking for ways to help the retirement age population. Recently a special center was set up within the Institutes of Health to devote its time exclusively to the aged. Outside government, voluntary groups have also been at work on the same subject.

Now the ideas developed by the years of discussion are coming to the surface in the form of legislation. Several of the bills would set up commissions, appointed either by the President or Congress. Another recommends that an existing House Committee make a study of the aging, similar to that suggested for the various commissions.

The commissions and committees would have one thing in common: They would further study and investigate in a field that many persons believe already has been plowed and replowed by investigators.

Several lawmakers want to get going right away. They would set up within the Department of Health, Education, and Welfare a new Bureau of Older Persons, which immediately would start out to solve some of the problems through grants, demonstrations and more research.

Most controversial of the "help the aged" bills is one originally proposed by the then Social Security Administrator, Oscar Ewing, in 1951. It would allow 60 days a year of government-paid hospitalization every year for persons covered by OASI after they reach age 65. They could have this free service whether or not they were on retirement.

As in most Congresses, those who want to get the veterans more benefits and those who think they are getting too much already are coming to grips over new bills. Important in this group is a measure proposed by Chairman Teague (D., Texas) of the House Veterans Affairs Committee that would tighten up procedures under which veterans with non-service-connected conditions receive hospitalization. But at the same time there is pressure from other quarters for a lengthening of the "presumptive periods" for various diseases. Where the law now states that a certain disease or condition will be considered service-connected if diagnosed within one year after the veteran's discharge, these bills would make the period two or three years.

Many other bills aimed at liberalizing veterans' benefits in various ways also are awaiting committee action.

Social security and taxes are other popular fields for the legislators. As expected, several bills call for lowering the age at which a disabled person can start receiving his social security pension, now set at 50. Many measures would change the income tax laws to allow more credit for medical expenses, and one proposes allowing the taxpayer to deduct premiums for health insurance from his income tax itself.

Of major interest to physicians and most self-employed is the Jenkins-Keogh legislation, which would allow deferment of taxes on a portion of income put into retirement plans.

Again, a number of lawmakers want the federal government to take a more active part in control of narcotics, barbiturates and amphetamines and treatment of addicts. One suggestion is to consider any shipment of barbiturates or amphetamines as a part of interstate commerce, on the theory that intrastate control is essential to interstate control. This and other bills also call for strict record-keeping and registration (physicians excepted from these provisions).

A plan introduced in the last session and offered again would give the President the right to assume control over the production distribution and use of any drugs or biologicals "for use in the prevention and treatment of disease."

Other medical bills will of course be introduced as the session moves on; those discussed here already are assured of considerable attention.

an effective adjunct to therapy

of common dermatoses

prolonged antibacterial action – emollient effect

no irritation – french-milled – noncrumbling

ETHICON

PR REPORT

NEW FILMS ADDED TO MSMS FILM LIBRARY

Doctors who anticipate giving court testimony on a traffic accident or other personal injury cases will be relieved to know that the MSMS Film Library has three new films that will help them prepare for their coming ordeal. Truly, ALL doctors will find these films valuable. In fact, they are highly recommended for showing at county medical society meetings.

Medical Witness is the first of new AMA series on doctor-lawyer relations, having been produced in co-operation with the American Bar Association. The film depicts right and wrong methods of presenting medical testimony by re-enacting the trial of a personal injury case. *Medical Witness* is a 30-minute, black and white, 16 mm. sound film.

On Impact, a behind-the-scenes documentary film, shows an entirely new approach to automobile safety that can save a half-million persons annually from highway injuries. Included are scenes of actual automobile test crashes staged to test new safety developments. The 14-minute, black and white sound film was produced for the AMA by the Ford Motor Company.

The Case of the Doubting Doctor is a dramatic film which gets right to the heart of some of the misunderstandings about medical societies — yet brings home positively the tremendous values of medical organizations from the county society right on to the national level. Produced by the AMA, the 30-minute color sound motion picture is designed to stimulate greater member participation, create a better informed membership and enhance appreciation of society services.

LT ANTIDOTE FOR TL

There's nothing like a Locum Tenens as an antidote for Tense Living.

Need a vacation? Want some temporary help in your office during the summer resort rush? Or would you just like a breather from a heavy patient load? Maybe a Locum Tenens is the answer.

The M.D. Placement Service of the Michigan Health Council maintains a list of young doctors of medicine who are seeking temporary positions. Some of these M.D.s want openings right now. Others will be ready this summer. And the time they can spend as a Locum Tenens ranges from six weeks to a year.

A letter or telephone call to the Michigan Health Council, M.D. Placement Service, 706 North Washington Avenue, Lansing 6, Michigan, will put you in touch with the practitioner you might need to give you a hand for a short time. So take advantage of this free service if you need assistance on a temporary basis.

Rather than wait until the last minute to find a Locum Tenens, however, the M.D. Placement Service recommends this procedure. As soon as you know the approximate dates you might need short-term help in your practice, list your opening with the Service. This allows plenty of time for making the necessary arrangements with an M.D. seeking such a position as you offer.

SPEAKERS ON PLASTIC SURGERY

County medical societies may arrange for scientific speakers on the subject of plastic surgery by contacting the Michigan Academy of Plastic Surgeons, according to an announcement by Robert J. Meade, M.D., Lansing, Secretary of the newly formed organization.

Doctor Meade said that members had offered to speak to medical societies and other groups in an effort to relate new developments in plastic surgery to practicing doctors of medicine. The Academy asks that requests be made eight weeks in advance if possible. Write Robert J. Meade, M.D., Secretary, Michigan Academy of Plastic Surgeons, 1023 East Michigan, Lansing 12, Michigan.

IT'S STEADY WORK BUT NOT MUCH ELSE

With eight years of socialized medicine experience, some 40,000 British doctors are talking of going on what amounts to a strike. Their incomes have been frozen since 1951. and they want a 24 per cent pay boost to keep them abreast of Britain's inflated living costs.

This state of affairs presents the best argument against socialized medicine we've encountered. With the individual's personal ability of such small account, and with no incentive to be superior, we can't see much future for British medicine's ability to attract men who aren't mediocre.

And it's highly alarming to think of the sick and the hurt having to put their faith in practitioners who went into medicine because it offers steady work (even if the pay is poor) and a white collar. In light of what's happened to Britain's 40,000 unhappy doctors, that appears to be about the most that can be said for the profession under socialized medicine.

We can't imagine that many people would be happy over calling in a doctor who assessed his profession that way.—*Detroit Free Press,* Wednesday, January 16, 1957.

announcing...

chemically conditioned

ACHROMYCIN V

ACHROMYCIN* V

Tetracycline Buffered with Sodium Metaphosphate

Chemically Conditioned To Produce Higher—Faster Blood Levels

ACHROMYCIN V combines the well-known antibiotic tetracycline with metaphosphate to provide greater and more rapid absorption of the antibiotic in the intestinal tract. This increased absorption is evidenced by significantly higher blood levels and by an increase in the excretion of the ingested drug in the urine. It is thought that this beneficial absorption is brought about by the chelating effect of the metaphosphate in the intestinal tract.

*Reg. U. S. Pat. Off.

Each capsule (pink) contains: Tetracycline equivalent to 250 mg. tetracycline HCl; Sodium Metaphosphate 380 mg.

The chemical structure of ACHROMYCIN remains unaltered. However, its tetracycline action is intensified. Chemically conditioned with metaphosphate, ACHROMYCIN V offers increased clinical efficiency. ACHROMYCIN V is indicated in all conditions indicated for ACHROMYCIN Tetracycline, and the recommended dose remains the same—one gram per day for the average adult.

ACHROMYCIN V places a newer, more effective therapeutic agent in the hands of the physician.

ACHROMYCIN V

chemically conditioned for

greater antibiotic absorption

faster broad-spectrum action

Available:
Vials of 16 and Bottles of 100 Capsules.

Each capsule (pink) contains:

Tetracycline equivalent to tetracycline HCl . . . 250 mg.

Sodium metaphosphate... 380 mg.

Dosage: 6—7 mg. per lb. of body weight for adults and children.

Lederle LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK

Typical Sanka Booth At Medical Conventions All Over The Country

Your verdict was "DELICIOUS!"

and your patients will agree

"This is for me—because I love good coffee!" Comments like this were heard at the Instant Sanka booth at the medical convention.

Good evidence that if you're a coffee lover, you'll enjoy Instant Sanka. Because Instant Sanka is 100% pure coffee—rich and full-bodied. Only caffein has been removed.

And just as a reminder—why not tell your caffein-sensitive patients about Instant Sanka Coffee? They can drink as much Instant Sanka as they want without being bothered by sleeplessness or jitters due to caffein.

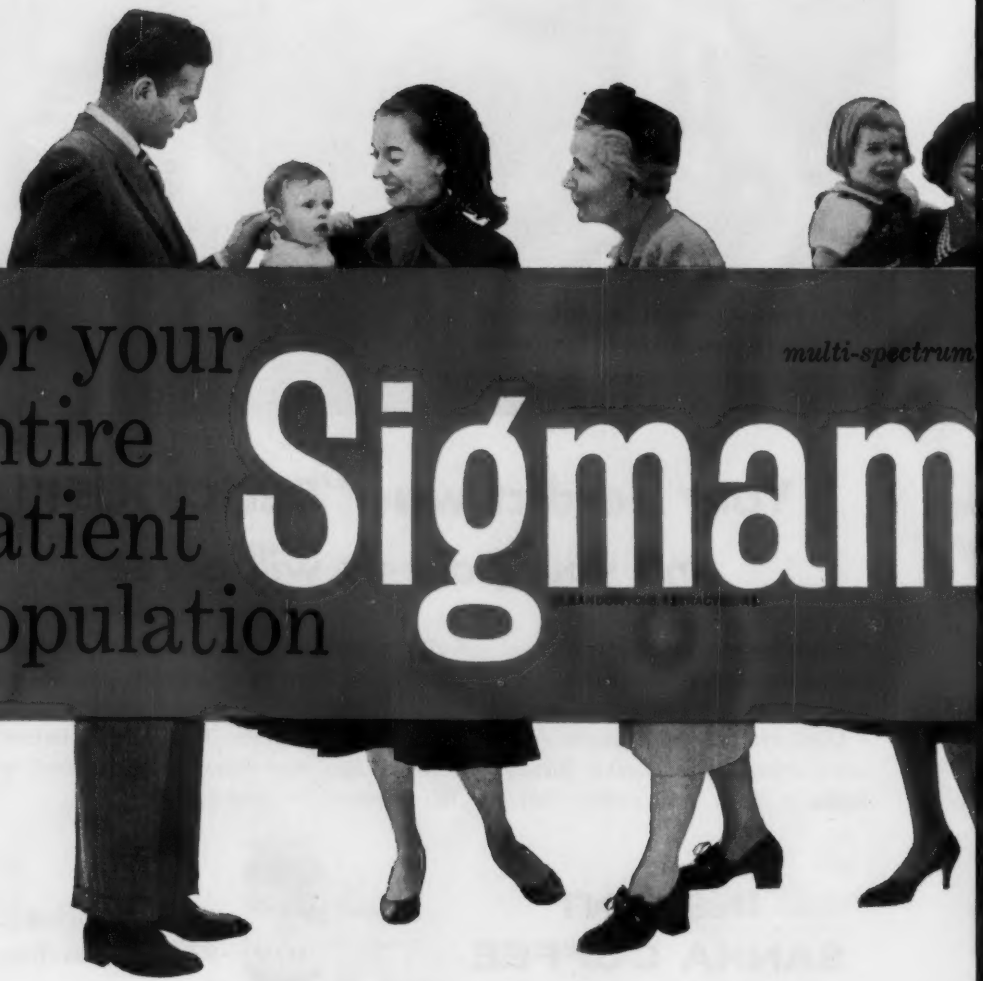
INSTANT SANKA COFFEE

All pure coffee...
97% caffein-free

Product of General Foods

added certainty in antibiotic therapy

—particularly for that 90% of the patient population treated in home or office where sensitivity testing may not be practical . . .



for your entire patient population

multi-spectrum

Sigmamy

00% EFFECTIVE in respiratory infections ncluding the 25% due to resistant taphylococci.[1-3]

)7% EFFECTIVE in dermatologic and mixed oft tissue infections including the 22% esistant to one or more antibiotics.[3-6]

)4.6% EFFECTIVE in genitourinary infec- ions including the 61% resistant to other ntibiotic therapy.[2,5]

)3% EFFECTIVE in diverse infections includ- ng the 21% due to resistant pathogens.[1,5]

)8.7% EFFECTIVE in tropical infections in- luding those complicated by heavy bacte- ial contamination or multiple parasitisms.[7]

1. Carter, C. H., and Maley, M. C.: Antibiotics Annual 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 51. 2. Shalowitz, M., and Sarnoff, H. S.: Personal communication. 3. Shubin, M.: Personal communication. 4. La Caille, R. A., and Prigot, A.: Antibiotics Annual 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 67. 5. Winton, S. S., and Cheserow, E.: Antibiotics Annual 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 55. 6. Cornbleet, T.: Personal communication. 7. Loughlin, E. H.; Mullin, W. G.; Alcinder, L., and Joseph, A. A.: Antibiotics Annual 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 63.

†the antimicrobial spectrum of tetracycline extended and potentiated with oleandomycin (Matromycin®) to combat resistant strains of pathogens—particularly resistant staphylococci —and to delay or prevent the emergence of new antibiotic-resistant strains.

SUPPLY
CAPSULES: 250 mg. (oleandomycin 83 mg., tetracycline 167 mg.). Bottles of 16 and 100.
new mint-flavored ORAL SUSPENSION: 1.5 Gm., 125 mg. per 5 cc. teaspoonful (oleandomycin 42 mg., tetracycline 83 mg.) 2 oz. bottle.

*TRADEMARK

Pfizer PFIZER LABORATORIES, *Division, Chas. Pfizer & Co., Inc.,* Brooklyn 6, N. Y.
World leader in antibiotic development and production

AMA News Notes

AMA SPONSORS DOCTOR-LAWYER MEETINGS

More than 300 doctors and lawyers in Atlanta, Denver and Philadelphia will get together this month (March) at the invitation of the American Medical Association to discuss mutual problems of the two professions. The day-and-a-half meetings have been scheduled as a follow-up to three similar sessions held in other cities in the fall of 1955. Dates and locations for the Friday and Saturday symposiums are: March 15-16 at the Atlanta-Biltmore Hotel, Atlanta; March 22-23 at the Cosmopolitan Hotel, Denver, and March 29-30 at the Benjamin Franklin Hotel, Philadelphia.

Topics to be discussed include trauma and disease, medical expert testimony and the medical witness. On Friday afternoon, Dr. Herman A. Heise of Milwaukee will speak on the use and background of scientific tests for intoxication to be followed by a mock trial demonstration. Participants in the mock trial include AMA staff personnel and Lt. Robert Borkenstein, inventor of the testing device known as "Breathalyzer."

On Saturday morning, a doctor-lawyer panel will discuss trauma and cancer followed by a question and answer period. After luncheon, Irving Goldstein, a Chicago attorney, author of "Trial Technique, Medical Trial Technique" and editor of *Medical Trial Technique Quarterly*, will speak on the medical witness and expert medical testimony. Winding up the program will be a showing of the movie, "The Medical Witness," and a question period.

American Medical Association and American Bar Association representatives will be at each meeting. AMA spokesmen in Atlanta and Philadelphia will be Dr. David B. Allman, president-elect, and in Denver, Dr. George F. Lull, secretary-general manager. ABA representatives include—in Philadelphia, David Maxwell, president; Atlanta, E. Smythe Gambrell, immediate past president, and Denver, Thomas M. Burgess, member, board of governors.

Registration fee for each symposium will be $5.00 to cover the cost of the luncheon and any published proceedings. Advance registrations should be sent immediately to the AMA Law Department.

NEW SLIDEFILM PINPOINTS QUACK DEVICES

More than a dozen mechanical quack devices and gadgets play the villain in a color slidefilm with sound just released by the AMA Bureau of Investigation. The 15-minute filmstrip, "Mechanical Quackery," is supplemented by narrative description of the devices and the fraudulent uses to which they have been put. It is available—on loan—to medical societies, service and fraternal groups and schools.

Oliver Field, Bureau director, describes the film as a public education experiment. "The slidefilm is a flexible and effective medium to use in exposing some of the quacks to the public," he said. "It may be used by medical societies or individual doctors as a tool in a concerted program to fight quackery. It is valuable, too, when used by lay or professional groups to alert their members or the community to the harm caused by quacks who use these worthless machines and devices as cure-alls."

Twenty-five sets of the film and record are in the Bureau of Investigation's lending library. Requests should be addressed to the Bureau. (Note: Equipment needed to show "Mechanical Quackery:" A sound slidefilm projector—or a filmstrip projector with a 33⅓ RPM turntable. Strip has 60 frames. Record is 12-inch.)

NEW MEDICOLEGAL FILM

A new medicolegal film on professional liability will be premiered Wednesday evening, June 5, during the AMA's Annual Meeting in New York City. This film, second in a series of six on various medicolegal problems, is being produced by the Wm. S. Merrill pharmaceutical company in cooperation with the American Medical Association and the American Bar Association. C. Joseph Stetler, director, AMA Law Department, reports a tremendous interest among both doctors and lawyers in the first film, "The Medical Witness," which was first shown at the 1956 Clinical Session in Seattle.

COLD WEATHER DAMAGES EXHIBIT

Even babies embedded in solid blocks of plastic have to be sheltered from the cold. Five of the twelve fetuses embedded in plastic blocks for the AMA exhibit, "Life Begins," were damaged recently by exposure to below freezing temperatures while enroute to Springfield, Illinois, for showings by the Illinois State Department of Public Health. Preservatives inside expanded, splitting the plastic blocks. The AMA Bureau of Exhibits reports that the five fetuses are being reset at the University of Illinois.

AREA MEDICAL SERVICE MEETINGS

A number of regional meetings have been scheduled this spring by committees of the AMA Council on Medical Service. Representatives of similar state committees will be invited to each session.

Committee on Maternal and Child Care.—March 30-31 in Philadelphia for the New England and Middle Atlantic states. Group will consider proposed guides for perinatal death studies similar to those prepared for maternal death studies.

Committee on Federal Medical Services.—March 16 in Reno, Nevada, for the Rocky Mountain and Pacific Coast states; April 6 in New York City for the New England and Middle Atlantic area. Principal discussion topic will be the AMA policy on care for veterans with

(Continued on Page 298)

'Thorazine' relieved this patient's severe anxiety and helped her to gain insight.

"No X-ray sees my cancer."

"... nothing stops my pain."

'THORAZINE' CASE REPORT

patient: 60-year-old female. After death of relative from cancer, patient developed severe epigastric pain, was convinced pain was due to hidden malignancy which defied the X-ray. Her pain was unresponsive to antispasmodics. Her severe cancerphobia was untouched by sedatives and she refused psychotherapy.

response: Complete relief from pain was obtained after two weeks of 'Thorazine' (25 mg. q.i.d.). Dosage was gradually decreased over the next two months to a 25 mg. tablet on retiring.

Patient then stated she "knew all the time it wasn't cancer." 'Thorazine' was instrumental in providing both relief and insight when "many drugs and attempts at reassurance had failed."

This case report is from the files of the patient's physician; photo professionally posed.

THORAZINE* one of the fundamental drugs in medicine

Smith, Kline & French Laboratories, Philadelphia

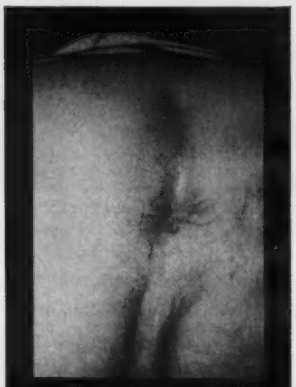
*T.M. Reg. U.S. Pat. Off. for chlorpromazine, S.K.F.

BEFORE
Reddened, fissured and excoriated perianal skin, and whitening of the anal folds, accompanied by intense burning and itching of 3 years' duration.

A new therapeutic approach with inherent safety in PRURITUS ANI

HYDROLAMINS®

TOPICAL AMINO ACID THERAPY



AFTER
Same case after treatment with Hydrolamins. Note healing of the inflamed, fissured and excoriated areas and of the whitened anal folds.

Unique physiologic barrier—topical amino acids—brings rapid relief (98%[1]) and complete healing (88%[1])

"...the objectives of therapy in pruritus ani can be listed under 3 headings:

(1) **relieve itching:** [Hydrolamins produced immediate relief of intractable itching in 98% of patients. The antipruritic effect of one application lasts about twenty-four hours.[1]]

(2) **accelerate healing,** [Hydrolamins rapidly and completely healed reddened, fissured, macerated and ridged perianal lesions in 88% of cases.[1]]

(3) **allow natural healing without trauma due to physical, chemical, allergic, or microbiologic agents."[2]** [The amino acids of Hydrolamins promote safe, natural healing while the ointment protects the perianal area from irritation.[1]]

Due to the rapidity of action of Hydrolamins, it is believed that protein-precipitating irritants, responsible for the pruritus, are neutralized. Hydrolamins also forms a biochemical barrier against further irritation.

SUPPLIED: In 1 oz. and 2.5 oz. tubes.

Lewal *Pharmaceutical Company, Chicago 14, Illinois*

1. Bodkin, L.G., and Ferguson, E.A., Jr.: Successful Ointment Therapy for Pruritus Ani, Am. J. Digest. Dis. 18:59 (Feb.) 1951.
2. Fromer, J.L.: Dermatologic Concepts and Management of Pruritus Ani, Am. J. Surg. 90:805 (Nov.) 1955.

'LANOXIN'* brand DIGOXIN

provides the

greater margin of safety

of a brief latent period

and optimum rate of elimination

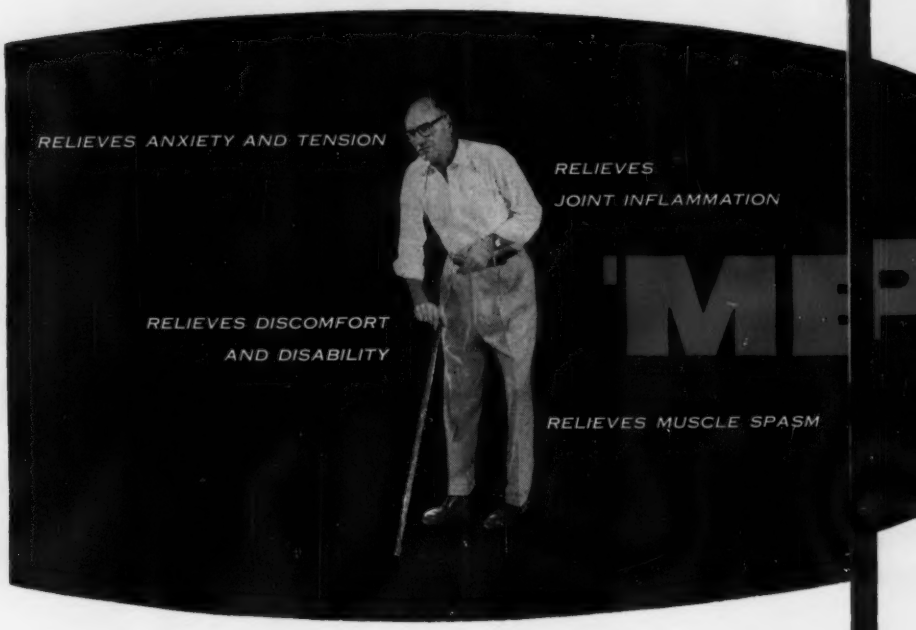
for dependable
digitalization and maintenance

Tablets: 0.25 mg. (white) and 0.5 mg. (green)
Pediatric Elixir: 0.05 mg. in each cc.
Ampuls: 0.5 mg. in 2 cc.

*'Lanoxin' was formerly known as Digoxin 'B. W. & Co.' The new name has been adopted to make easier for everyone the distinction between digoxin and digitoxin.

BURROUGHS WELLCOME & CO. (U. S. A.) INC., *Tuckahoe, New York*

NEW...



Each Multiple Compressed Tablet of MEPROLONE provides the inseparable antiarthritic, antirheumatic benefits of:

1. *Prednisolone buffered*—the newest and most potent of the "predni-steroids" for prompt relief of joint pain and arrest of the destructive inflammatory process.

2. *Meprobamate*—the newest and safest of the muscle-relaxant tranquilizers for profound relaxation of skeletal muscle in spasm.

Tolerance to this combination is good because there is little likelihood of sodium retention, potassium depletion or gastric distress with buffered prednisolone, and meprobamate rarely produces significant side effects in therapeutic dosage.

An additional important therapeutic benefit, often overlooked, stems from the tranquilizing action of meprobamate. This component of MEPROLONE relieves mental tension and anxiety so often manifest in arthritics, making them more amenable to other rehabilitation measures.

INDICATIONS: A wide variety of conditions, in which four symptoms predominate: *a*) inflammation *b*) muscle spasm *c*) anxiety and tension *d*) discomfort and disability; i.e., rheumatoid arthritis, rheumatoid spondylitis (Marie-Strümpell disease), Still's disease, psoriatic arthritis, osteo-

Therapeutic benefits of MEPROLONE compared with traditional antiar

	relieves pain	suppresses inflammation	relaxes muscle	eases anxiety	imp... son... well...
Salicylates	✓	✓			
Muscle relaxants			✓1		
Tranquilizers				✓1	
Steroids	✓	✓			✓
MEPROLONE	✓	✓	✓	✓	✓

1. Meprobamate is the only tranquilizer w... muscle-relaxant acti...

arthritis, bursitis, synovitis, tenosynovitis, myositis, ... sitis, fibromyositis, neuritis, acute and chronic low ... pain, acute and chronic primary and secondary fibr... and torticollis, intractable asthma, respiratory alle... allergic and inflammatory eye and skin disorders (as ... tenance therapy in disseminated lupus erythemat... periarteritis nodosa, dermatomyositis and scleroder...

SUPPLIED: Multiple Compressed Tablets in bott... 100 in two formulas as follows: MEPROLONE-1—1.0... of prednisolone, 200 mg. of meprobamate and 200 m... dried aluminum hydroxide gel. MEPROLONE-2—pro... 2.0 mg. of prednisolone in the same formula.

Say you saw it in the Journal of the Michigan State Medical Society

NO OTHER

ANTIRHEUMATIC

PRODUCT

PROVIDES AS MANY

BENEFITS AS

MEPROLONE'

MEPRO PREDNISO | BAMATE LONE, *buffered*

THE ONLY

ANTIRHEUMATIC,

ANTIARTHRITIC

THAT SIMULTANEOUSLY

RELIEVES:

1. MUSCLE SPASM
2. JOINT INFLAMMATION
3. ANXIETY AND TENSION
4. DISCOMFORT AND DISABILITY

MSD

MERCK SHARP & DOHME

DIVISION OF MERCK & CO., Inc. PHILADELPHIA 1, PA.

MEPROLONE is the trade-mark of Merck & Co., Inc.

AREA MEDICAL SERVICE MEETINGS

(Continued from Page 292)

non-service-connected disabilities in Veterans Administration hospitals.

Committee on Aging.—April 27-28 in Dallas, Texas, for the Southwestern states. Over-all problems in the field of aging and the role of medicine and medical societies in meeting these problems will be discussed.

"MARCH OF MEDICINE" PROGRAM ON MISSIONARY MEDICINE REPEATED

Overwhelming response from physicians, churchmen, television writers and viewers has prompted March of Medicine to repeat its hour-long documentary on missionary medicine Tuesday, March 5, at 9:30 p.m. EST over the NBC-TV network. This latest in the prize-winning TV series, produced and sponsored by Smith, Kline and French Laboratories in cooperation with the American Medical Association, is called "Monganga," tribal dialect for "white doctor." Originally televised November 27, it brought a heavy flow of enthusiastic letters, telegrams, phone calls and personal messages—many asking to see the program again.

The show chronicles the daily labors of a medical missionary, Dr. John Ross, as an "illustration of the work American doctors are doing for sick people all over the world." Doctor Ross is shown at his 14-hour day—overseeing his clinic and a nearby leprosarium, conducting a weekly pre-natal clinic, traveling to distant "bush clinics."

"NOMENCLATURE" INSTITUTE IN INDIANAPOLIS

The American Medical Association recently announced that a short course on the use of the **Standard Nomenclature of Diseases and Operations** in the doctor's office, clinic or hospital will be held June 17-19 at the Indiana University Medical Center, Indianapolis. Two other "Institutes" have been scheduled in 1957: March 11-13 in Roanoke, Virginia, and August 5-7 in San Francisco. These three-day meetings are conducted by the AMA as a special service to medical record librarians and others using the **Nomenclature** in their work. Tuition is free. Applications should be sent to Mrs. Adaline C. Hayden, C.R.L., associate editor of the **Nomenclature**, at AMA Headquarters, Chicago.

FILM ON HEREDITY AVAILABLE

The basic story of heredity, sex determination, sex roles and attitudes within the framework of heredity and environment is dramatically told in a new color film which has recently been added to the AMA Film Library. The 18-minute sound film, "Human Heredity," was designed primarily for junior high students although older persons also will find it informative. One of the primary purposes of this 16mm film is to stimulate group discussion on this extremely important health subject. Medical societies may book the film through AMA's Council on Scientific Assembly Motion **Pictures and Medical Television.**

NEWSCOPES

The American Medical Education Foundation wound up its fifth year of operation with a record total of $1,072,717 in contributions for the country's 83 medical schools. This represents a 41 per cent increase over the previous year. . . . The Committee on Relationships Between Medicine and Allied Health Agencies—a committee of the AMA Board of Trustees—recently developed a brief statement designed to assist medical societies in this activity. Copies are available to physicians from the Council on Medical Service. . . . Limited supplies of the booklet, "Fitness of American Youth—A Report to the President of the U. S. on the Annapolis Conference," are available to physicians from the AMA Bureau of Health Education. This summarizes the findings and recommendations of the 149 national leaders in government, medicine, education, recreation, public health, sports, civic and youth programs who met last June to consider the problems of physical activity for young people. AMA representatives included Dr. Elmer Hess, immediate past president, and Dr. W. W. Bauer, director, Bureau of Health Education.

THE EARLY BIRD CATCHES THE WORM

The Sears-Roebuck Foundation announces that applications for financial assistance to physicians desiring to enter private practice are currently being processed for the first half of 1957. The deadline for receiving applications is April 1, with final determination on who will receive assistance no later than June 15. All applications are reviewed by a 17-member Medical Advisory Board who use as the sole criteria for loan evaluation the medical need of the community and the financial, need of the physician.

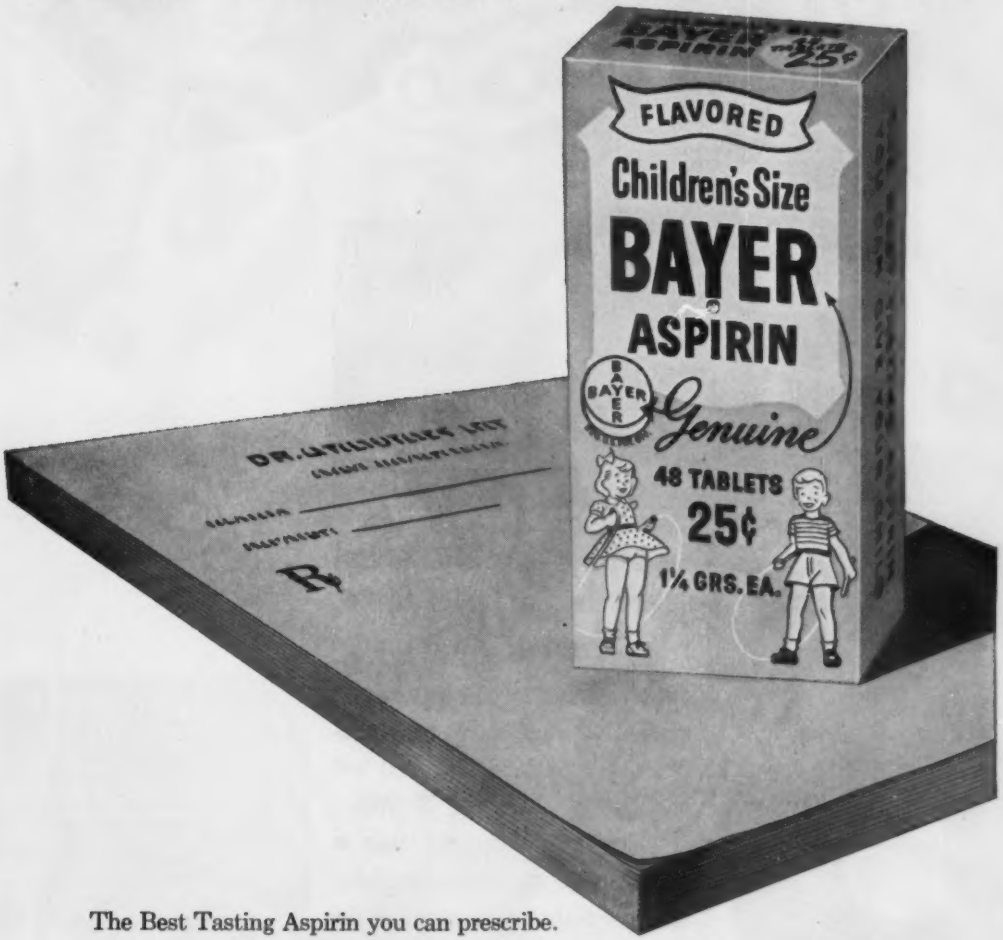
The Foundation makes an annual grant of $125,000 to a revolving assistance fund for the purpose of making supplemental, 10 year, unsecured loans to physicians interested in establishing or improving facilities in suburban, rural or small town communities. These loans can be used for new building construction, remodeling, purchase of equipment, and for supplemental expenses connected with establishing a practice. The interest rate of these loans ranges from zero to six per cent depending on the rapidity of repayment.

This is an ideal time for graduating internes and residents who are interested in entering private practice but lack the necessary funds to apply since, if chosen, the funds will be available upon graduation in July. A Foundation spokesman urged all interested physicians to apply immediately and not wait for the April 1 deadline to insure proper processing of applications. Applications may be obtained from county or state medical societies, AMA's Council on Medical Service, or from the Sears-Roebuck Foundation, 3333 W. Arthington, Chicago, Illinois.

There is no single therapy which can be applied with universal success at any time in the development of bone cancer.

little

How to win friends ...



The Best Tasting Aspirin you can prescribe.

The Flavor Remains Stable down to the last tablet.

25¢ Bottle of 48 tablets (1¼ grs. each).

We will be pleased to send samples on request.

THE BAYER COMPANY DIVISION of Sterling Drug Inc. 1450 Broadway, New York 18, N. Y.

Successful appetite control begins in the supermarket

If your overweight patient can resist the temptation to buy high calorie snacks, he's well on the road to successful weight reduction. You will find that one Dexedrine* Spansule sustained release capsule taken in the morning controls appetite all day long—both at mealtimes and in the supermarket.

SKF

*T.M. Reg. U.S. Pat. Off. for dextro-amphetamine sulfate, S.K.F. †T.M. Reg. U.S. Pat. Off.

NOW—EFFECTIVE STEROID HORMONE THERAPY OF RHEUMATIC AFFECTIONS WITH GREATER SAFETY AND ECONOMY

PABALATE-HC

Robins

Pabalate with Hydrocortisone

Clinical evidence indicates that, in Pabalate-HC, the synergistic antirheumatoid effects of hydrocortisone, salicylate, para-aminobenzoate, and ascorbic acid achieve satisfactory remission of symptoms in *up to 85% of cases studied*

—with a much higher degree of safety

—even when therapy is maintained for long periods

—at significant economy for the patient

Each tablet of Pabalate-HC contains 2.5 mg. of hydrocortisone—50% more potent than cortisone, yet not more toxic.

FORMULA

In each tablet:

Hydrocortisone (alcohol)	2.5 mg.
Potassium salicylate	0.3 Gm.
Potassium para-aminobenzoate	0.3 Gm.
Ascorbic acid	50.0 mg.

DOSAGE: Two tablets four times daily. Additional information on request.

AVAILABLE FOR YOUR PRESCRIPTION **NOW**

A. H. ROBINS CO., INC. **RICHMOND 20, VIRGINIA**

Ethical Pharmaceuticals of Merit since 1878

Erythromycin in Treating Pneumonia

A 27-year-old man, a chronic alcoholic, was admitted with a history of an alcoholic spree followed by a cough, greenish sputum and chills and fever.

Physical examination showed a temperature of 104 F. and indicated pneumonia in the right lower lobe. This was confirmed by X-ray. The sputum revealed gram-positive diplococci and blood culture subsequently grew Type VII pneumococci.

The patient was treated with erythromycin, 300 mg. every six hours per os. His temperature dropped to normal by 48 hours and X-ray of the chest revealed considerable clearing by the fourth hospital day. After 10 days hospitalization, the patient was fit for discharge.[1]

First Antibiotics Symposium, we reported the successful treatment with hromycin of *H. influenzae* pneumonia and bacteremia. A second patient with *H. influenzae* pneumonia and bacteremia had a clinical course almost identical to the one previously reported, with cure obtained by treatment with 500 mg. of erythromycin per os every four hours for 14 days.

Of these 132 patients with bacterial pneumonia, 127 (96%) had a good clinical result. One patient with lobar pneumonia had a good initial response but had delayed resolution after

"Highly Effective in Pneumonia"

In one investigation, 75 adult patients with bacterial pneumonia were treated with erythromycin. In his summary, the clinician reported: "It is concluded that erythromycin is highly effective in the treatment of pneumonia due to gram-positive bacteria."[2]

This, of course, is only one of many reports showing the effectiveness of ERYTHROCIN against coccic infections. You'll get the same good results (nearly 100% in common, bacterial respiratory infections) when you prescribe ERYTHROCIN. Abbott

filmtab®

Erythrocin®

(Erythromycin, Abbott)

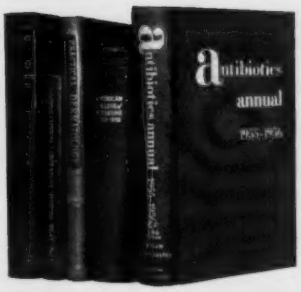
STEARATE

"No Serious Side Effects Occurred"

After a study of 171 patients treated with erythromycin, the investigator wrote: "No serious side effects occurred with prolonged therapy or with doses up to 8 Gm. per day in the severe infections."[1]

Actually, ERYTHROCIN stands on a remarkable record of safety. After four years, there's not a single report of a severe or fatal reaction attributable to erythromycin. In addition, you'll find allergic manifestations rarely occur. *Filmtab* ERYTHROCIN Stearate (100 and 250 mg.), in bottles of 25 and 100. Abbott

® Filmtab—Film-Sealed tablets, Abbott; pat. applied for.



1. Romansky, M.J., et al., Antibiotics Annual 1955-1956, p. 48,
2. Waddington, W. S., Maple, F. C., and Kirby, W. M. M., A.M.A. Archives of Internal Medicine, 1954, p. 556.

701051

now patients will enjoy your low-sodium diet

Taste CO-SALT and know why this different salt substitute so truly satisfies the cravings of your low-sodium diet patients for the flavor of salt.

CO-SALT so closely looks like, sprinkles like and tastes like salt . . . there is . . .

1. no "cheating" on the prescribed diet
2. patients enjoy their food again
3. patients are better nourished

Lithium-free, never bitter or metallic in taste, contains nothing that may deplete the system of phosphorus or other minerals. The only salt substitute that contains choline. For use at table or in cooking.

in congestive heart failure

toxemias of pregnancy

hypertension

obesity

INGREDIENTS: choline, potassium chloride, ammonium chloride and tri-calcium phosphate

available: 2 oz. shaker top package
8 oz. economy package

professional samples upon request

Accepted for advertising in the Journal of the American Medical Association.

arlington-funk laboratories

division of U. S. VITAMIN CORPORATION
250 East 43rd Street - New York 17, N. Y.

Say you saw it in the Journal of the Michigan State Medical Society

...IN URINARY COMPLAINTS

✳ *Sterilizes urine in 1 to 3 days*

✳ *Relieves burning in minutes*

✳ *Effective in 93-98% of cases*

sulfid

The original Azo-Sulfa Formula*
Antibacterial • Analgesic

LOCALIZED MUCOSAL ANALGESIA

Phenylazo-diamino-pyridine HCl—acts solely on the urogenital mucosa; provides prompt relief from burning, pain and frequency.

LOCALIZED ANTIBACTERIAL ACTIVITY

Sulfacetamide—eliminates mixed infections rapidly because of its unusual solubility in acid urine common to bacterial invasion of the urinary tract. No renal damage, concretions or anuria.

...and when Spasmolysis is essential

sulfid B-A

Antibacterial • Analgesic • Antispasmodic

—the dual activity of SULFID with the well-known antispasmodic effect of natural belladonna alkaloids.

FORMULAE:

SULFID—Each coated tablet contains: Phenylazo-diamino-pyridine HCl, 50 mg. and Sulfacetamide, 250 mg., in bottles of 100 tablets.

SULFID B-A—Each coated tablet contains the SULFID formula with natural belladonna alkaloids, 0.065 mg., in bottles of 100 tablets.

COLUMBUS PHARMACAL COMPANY—Columbus 16, Ohio

*Introduced—July, 1954

Meat Protein...

and the Many Physiologic Functions of Its Amino Acids

The amino acids supplied by meat protein function in many vital ways in addition to their well-known role in the growth and maintenance of tissues. They participate in the body economy as precursors of hormones, vitamins, enzymes, and other physiologic agents.*

Some of the important amino acids supplied by the protein of meat include: tryptophan (utilized for the endogenous production of niacin); tyrosine (the precursor of thyroxine and triiodothyronine); phenylalanine (converted to melanin, a pigment found in the skin, hair, retina, and other tissues; both phenylalanine and tyrosine are precursors of the hormones noradrenalin and adrenalin); glycine (participates in the formation of glutathione, a tripeptide important in tissue oxidation, in the biosynthesis of glycocholic acid, and in the production of purines, uric acid, and porphyrins used structurally for hemoglobin, cytochromes, and iron-containing enzymes); methionine (an important lipotropic agent; participates in transmethylation processes in which creatine, adrenalin, and choline phospholipids are formed).

Top quality protein, as supplied by meat, yields important amino acids for participation in these and other important functions. The excellent balance of available amino acids is an outstanding feature of meat protein.

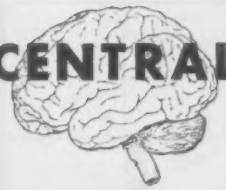
*Geiger, E.: Digestion, Absorption and Metabolism of Protein, in Wohl, M. G., and Goodhart, R. S.: Modern Nutrition in Health and Disease, Philadelphia, Lea & Febiger, 1955, pp. 98-143.

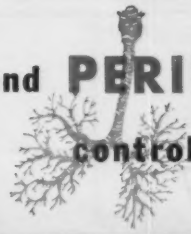
The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

American Meat Institute
Main Office, Chicago... Members Throughout the United States

Say you saw it in the Journal of the Michigan State Medical Society

Both CENTRAL and PERIPHERAL control of cough





SYNEPHRICOL® cough syrup

ANTITUSSIVE • DECONGESTANT • ANTIHISTAMINIC

Combines:

Central Antitussive Effect — mild, dependable
Topical Decongestion — prompt, prolonged

plus Antihistaminic and Expectorant Action

Winthrop LABORATORIES
NEW YORK 18, N. Y.

Each teaspoonful (4 cc.) contains:

[illegible] Hydrochloride	5.0 mg.
Thenfadiine hydrochloride	4.0 mg.
Dihydrocodeinone bitartrate	1.33 mg.
Potassium guaiacol sulfonate	70.0 mg.
Ammonium chloride	70.0 mg.
Menthol	1.0 mg.
Chloroform	0.02 cc.
Alcohol	8%

Bottles of 16 fl. oz.

EXEMPT NARCOTIC

Outguessing your "Second Guessers"
...always a serious problem in OBESITY!

It's easy with DIOCURB!

This New Dosage form of dextro amphetamine sulfate is *not readily recognizable* by the most astute patient!

DIOCURB
(Tutag Brand dextro amphetamine sulfate)

SMALL, RED, SOFT GELATIN SPHERES, containing 5 mg. dextro amphetamine Sulfate.

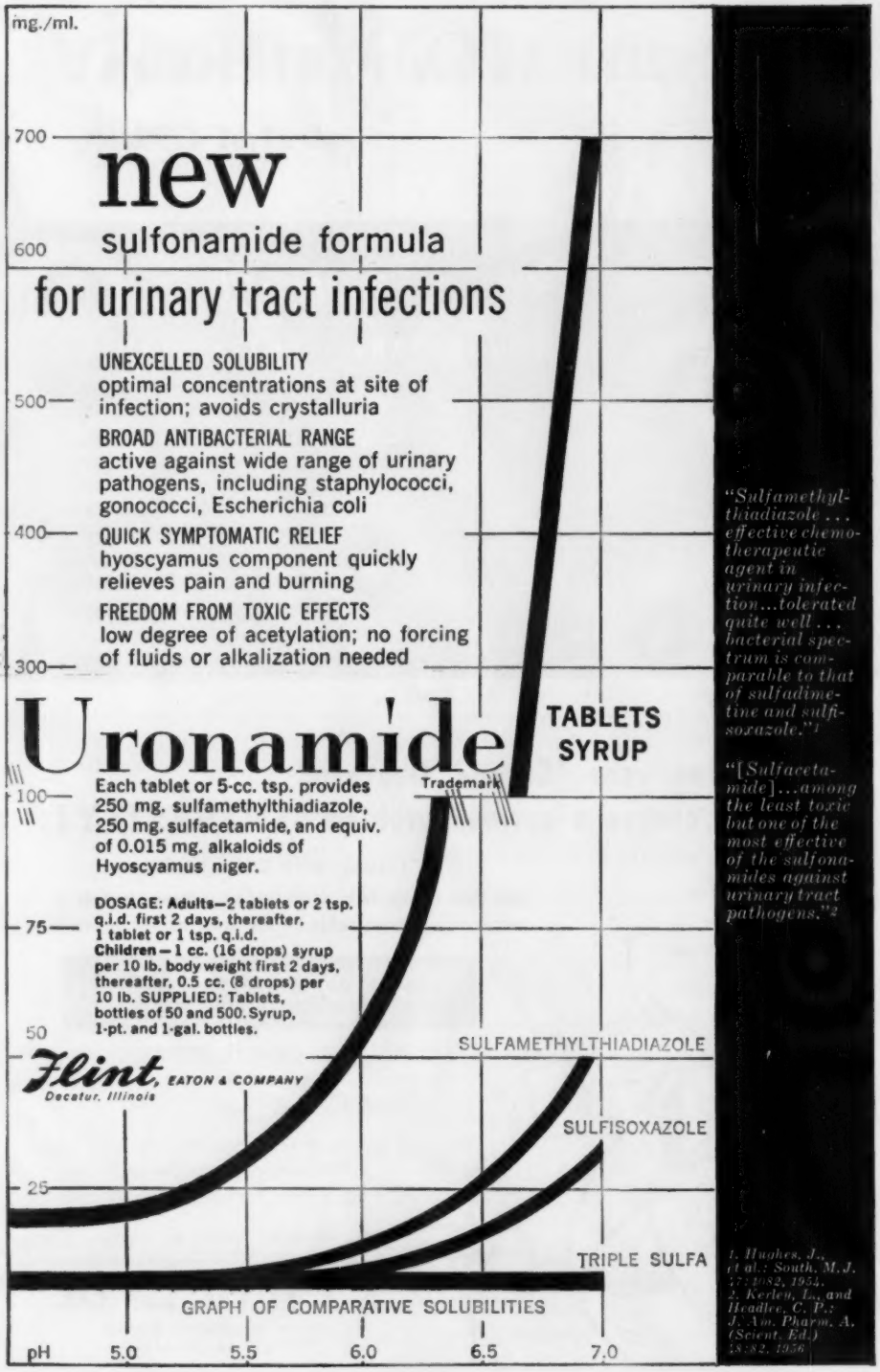
Especially Effective... in Obesity!

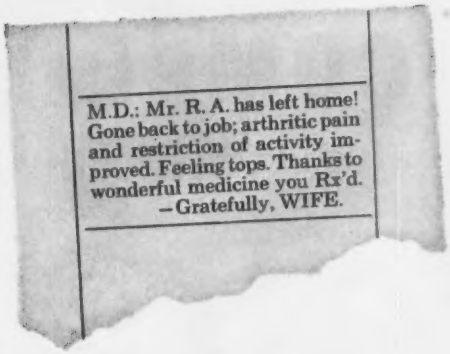
Thin wall capsule releases amphetamine in as little as 90 seconds! Nonaqueous vehicle and micron particle size assures maximum therapeutic response.

TUTAG

Sample and literature on request.

S. J. TUTAG and CO.
19180 Mt. Elliott Avenue
Detroit 34, Michigan


mg./ml.
700
600
500
400
300
100
75
50
25
new
sulfonamide formula
for urinary tract infections
UNEXCELLED SOLUBILITY
optimal concentrations at site of infection; avoids crystalluria
BROAD ANTIBACTERIAL RANGE
active against wide range of urinary pathogens, including staphylococci, gonococci, Escherichia coli
QUICK SYMPTOMATIC RELIEF
hyoscyamus component quickly relieves pain and burning
FREEDOM FROM TOXIC EFFECTS
low degree of acetylation; no forcing of fluids or alkalization needed
Uronamide
Trademark
TABLETS
SYRUP
Each tablet or 5-cc. tsp. provides 250 mg. sulfamethylthiadiazole, 250 mg. sulfacetamide, and equiv. of 0.015 mg. alkaloids of Hyoscyamus niger.
DOSAGE: Adults—2 tablets or 2 tsp. q.i.d. first 2 days, thereafter, 1 tablet or 1 tsp. q.i.d. Children—1 cc. (16 drops) syrup per 10 lb. body weight first 2 days, thereafter, 0.5 cc. (8 drops) per 10 lb. SUPPLIED: Tablets, bottles of 50 and 500. Syrup, 1-pt. and 1-gal. bottles.
Flint, EATON & COMPANY
Decatur, Illinois
SULFAMETHYLTHIADIAZOLE
SULFISOXAZOLE
TRIPLE SULFA
GRAPH OF COMPARATIVE SOLUBILITIES
pH 5.0 5.5 6.0 6.5 7.0
"Sulfamethylthiadiazole . . . effective chemotherapeutic agent in urinary infection . . . tolerated quite well . . . bacterial spectrum is comparable to that of sulfadimetine and sulfisoxazole."1
"[Sulfacetamide] . . . among the least toxic but one of the most effective of the sulfonamides against urinary tract pathogens."2
1. Hughes, J., et al.: South. M. J. 47: 1082, 1954.
2. Kerlen, L., and Headlee, C. P.: J. Am. Pharm. A. (Scient. Ed.) 38: 82, 1956



Sterane®

brand of prednisolone

Most active anti-rheumatic, anti-allergic, anti-inflammatory corticoid. White, scored 5 mg. tablets (bottles of 20 and 100) and pink, scored 1 mg. tablets (bottles of 100).

Pfizer **PFIZER LABORATORIES** Division, Chas. Pfizer & Co., Inc. Brooklyn 6, New York

relieves the discomfort of colds

'TABLOID'

'EMPIRIN' COMPOUND®

with CODEINE PHOSPHATE

shortens the "miserable" period by:

- Reducing fever
- Controlling cough
- Relieving headache
- Relieving muscular aches and pains

prompt symptomatic relief of colds with ***minimum addiction liability***

Available in four strengths

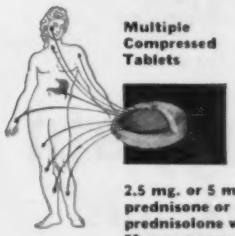
No. 1 **No. 2** **No. 3** **No. 4**

BURROUGHS WELLCOME & CO. (U. S. A.) INC., Tuckahoe, N. Y.

clinical evidence[1,2,3] indicates that to augment the therapeutic advantages of the "predni-steroids" antacids should be routinely co-administered to minimize gastric distress

ROUTINE CO-ADMINISTRATION MEANS

'Co-Hydeltra'
(Prednisolone Buffered)



Multiple Compressed Tablets

2.5 mg. or 5 mg. prednisone or prednisolone with 50 mg. magnesium trisilicate and 300 mg. aluminum hydroxide gel.

'Co-Deltra'
(Prednisone Buffered)

All the benefits of the "predni-steroids" plus positive antacid action to minimize gastric distress.

References: 1. Boland, E. W., *J.A.M.A.* 160:613 (February 25) 1956. 2. Margolis, H. M. *et al.*, *J.A.M.A.* 158:454 (June 11) 1955. 3. Bollet, A. J. *et al.*, *J.A.M.A.* 158:459 (June 11) 1955.

MSD
MERCK SHARP & DOHME
DIVISION OF MERCK & CO., INC.
PHILADELPHIA 1, PA.

DIABETES HISTORY

(Continued from Page 278)

complete body must be free from evidence of calcification in the arteries. The electrocardiogram must be normal.

The first such medal to be awarded in Western Michigan was given to Miss Janet Witteveen of Holland at the February 15 meeting of the Muskegon County Medical Society.

Miss Witteveen developed the usual symptoms of diabetes in January, 1930. She was examined by Dr. Wm. C. Kools of Holland who found sugar in the urine. He attempted control of the disease by diet alone but found it necessary to start insulin in November, 1930. In 1933, she was admitted to Presbyterian Hospital in Chicago under the late Dr. R. T. Woodyatt, who readjusted the insulin dosage. In 1940, she was under the care of Dr. Merrill Wells of Grand Rapids with the complaint of numerous insulin shocks. She was brought under better control at that time by a combination of P.Z.I. and unmodified insulin.

In March, 1954, at the age of thirty-six, she again was experiencing numerous shocks alternating with spells of hyperglycemia. She had an enlarged thyroid, nervousness, palmar perspiration, and other hyperthyroid symptoms. An isotope tracer study indicated hyperactivity of the thyroid and a therapeutic dose of I^{131} resulted in marked diminution of these symptoms.

During her first year on insulin, she required from thirty to forty units daily. In 1940, she was controlled on 44 units, and at the present time is well controlled on N.P.H. alone, two doses totaling 23 units. She was used in the experimental study of "Orinase" for a time, which made no difference in the degree of control or insulin requirement.

In November, 1955, she completed twenty-five years on insulin. A complete physical examination, x-rays, electrocardiogram and a thorough eye examination were done and forwarded to the Advisory Committee in Boston. Word has just been received that she has been awarded the medal and it was presented to her officially on February 15, 1957.

WILLIAM M. LEFEVRE, M.D.
Councilor, 11th District

NEW Rx

A.P.C. WITH Demerol® Tablets

Each tablet contains:

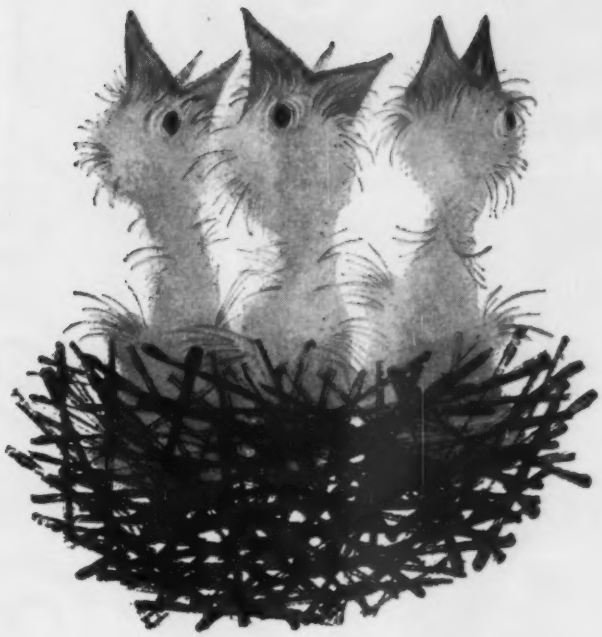
Aspirin	200 mg. (3 grains)
Phenacetin	150 mg. (2½ grains)
Caffeine	30 mg. (½ grain)
Demerol hydrochloride	30 mg. (½ grain)

Average Dose:
1 or 2 tablets.
Narcotic blank required.

Potentiated Pain Relief

WINTHROP LABORATORIES
New York 18, N. Y. • Windsor, Ont.

Demerol (brand of meperidine), trademark reg. U.S. Pat. Off.



children are often this eager...

Because Rubraton tastes so good, most children actually look forward to taking it. What better way could there be for providing these essential nutrients?

Rubraton is indicated for combatting many common anemias and for correcting mild B complex deficiency states. It may also prove useful for promoting growth and stimulating appetite in poorly nourished children. (Not intended for treatment of pernicious anemia.)

Dosage: 1 or 2 teaspoonfuls t.i.d.

Supply: Bottles of 8 ounces and 1 pint.

1 teaspoonful (5 cc.) supplies:

Elemental Iron (as ferric ammonium citrate and colloidal iron)	38 mg.
Vitamin B_{12} activity concentrate	4 mcg.
Thiamine mononitrate	1.0 mg.
Riboflavin	1.0 mg.
Niacinamide	5 mg.
Pantothenic acid (Panthenol)	1.5 mg.
Pyridoxine hydrochloride	0.5 mg.

Alcohol content: 12 per cent

RUBRATON

SQUIBB IRON, B COMPLEX AND B_{12} VITAMINS ELIXIR

"RUBRATON"® IS A SQUIBB TRADEMARK

SQUIBB Squibb Quality—the Priceless Ingredient

among nonhormonal antiarthritics . . .
unexcelled in
therapeutic potency

BUTAZOLIDIN®
(phenylbutazone GEIGY)

In the nonhormonal treatment of arthritis and allied disorders no agent surpasses BUTAZOLIDIN in potency of action.

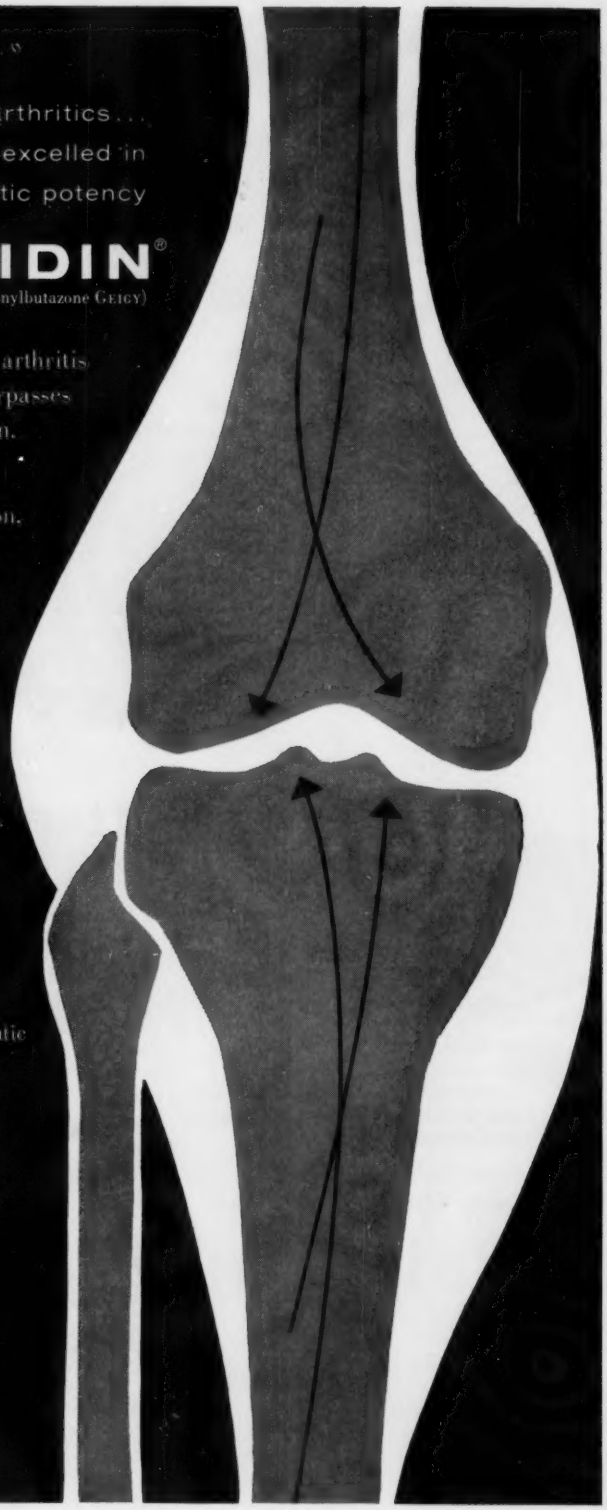
Its well-established advantages include remarkably prompt action, broad scope of usefulness, and no tendency to development of drug tolerance. Being nonhormonal, BUTAZOLIDIN causes no upset of normal endocrine balance.

BUTAZOLIDIN relieves pain, improves function, resolves inflammation in:
Gouty Arthritis
Rheumatoid Arthritis
Rheumatoid Spondylitis
Painful Shoulder Syndrome

BUTAZOLIDIN being a potent therapeutic agent, physicians unfamiliar with its use are urged to send for detailed literature before instituting therapy.

BUTAZOLIDIN® (phenylbutazone GEIGY). Red coated tablets of 100 mg.

GEIGY
Ardsley, New York



Say you saw it in the Journal of the Michigan State Medical Society

outstanding appetite stimulant

INCREMIN*

LYSINE-VITAMIN SUPPLEMENT LEDERLE

Problem-eaters, the underweight, and generally below-par patients of all ages respond to INCREMIN.

INCREMIN offers l-Lysine for protein utilization, and essential vitamins noted for outstanding ability to stimulate appetite, overcome anorexia.

Specify INCREMIN in either Drops (cherry flavor) or Tablets (caramel flavor). Same formula. Tablets, highly palatable, may be orally dissolved, chewed, or swallowed. Drops, delicious, may be mixed with milk, milk formula, or other liquid; offered in 15 cc. polyethylene dropper bottle.

Each INCREMIN Tablet
or each cc. of INCREMIN Drops *contains:*

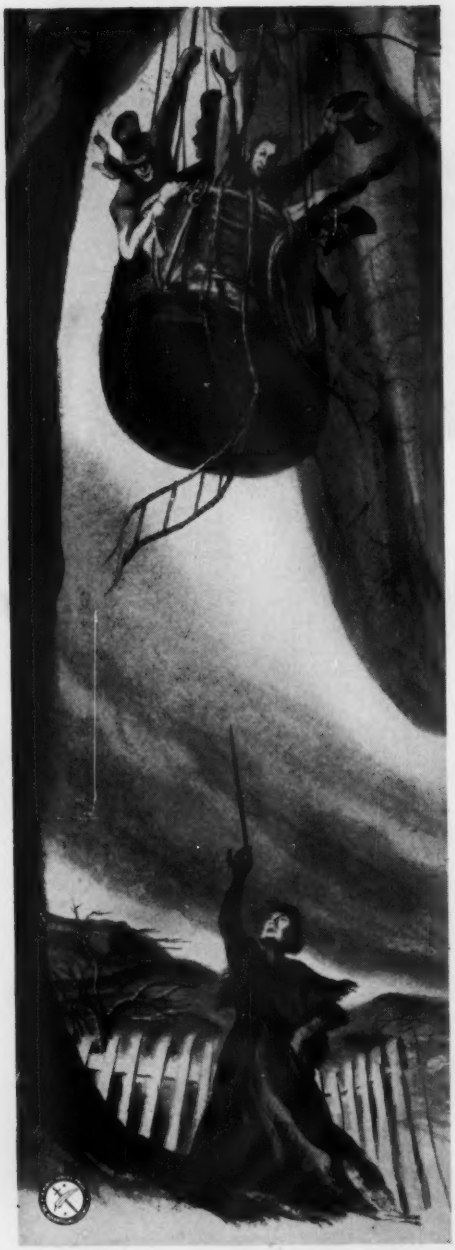
l-Lysine	300 mg.	Pyridoxine (B_6)	5 mg.
Vitamin B_{12}	25 mcgm.	(INCREMIN Drops contain 1% alcohol)	
Thiamine (B_1)	10 mg.		

Reg. U. S. Pat. Off.

Dosage only 1 INCREMIN TABLET or 10-20 INCREMIN Drops daily.

Lederle

LEDERLE LABORATORIES DIVISION
AMERICAN CYANAMID COMPANY
PEARL RIVER, NEW YORK



The old lady gave him what for

From AMERICAN HERITAGE

AN OLD LADY living near Henderson, N. Y. in 1859 was shocked at the way the four men had arrived—and said so. Such sensible-looking men in such an outlandish vehicle!

But John Wise and his crew, perched up in a tree, were far too happy to listen. Caught by a storm, their aerial balloon had almost plunged beneath the angry waves of Lake Ontario. Then, after bouncing ashore, they had crashed wildly through a mile of tree-tops before stopping in one.

Now, his poise regained, Wise stood up to proclaim: "Thus ends the greatest balloon voyage ever made." He had come 1200 miles from St. Louis in 19 hours, setting a record unbroken for 60 years.

He had also proved his long-held theory of an earth-circling, west-east air current—and that was far more important to him. For Wise was no carnival balloonist. He was a pioneer scientist of the air, a man whose inquiring mind and courageous spirit helped start the vast forward march of American aviation.

In America's ability to produce such men as John Wise lies the secret of her real wealth. For it is a wealth of human ability that makes our country so strong. And it is this same wealth that makes her Savings Bonds so safe.

168 million Americans back U. S. Savings Bonds—back them with the best guarantee you could possibly have. Your principal guaranteed safe to any amount—your interest guaranteed sure—by the greatest nation on earth. If you want *real* security, buy U. S. Savings Bonds. Get them at your bank or through the Payroll Savings Plan where you work. And hold on to them.

PART OF EVERY AMERICAN'S SAVINGS BELONGS IN U. S. SAVINGS BONDS

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NEW

for your

Rheumatoid Arthritis patient

for the pain of the present

for the fear of the future

the original tranquilizer-corticoid

Ataraxoid*

provides the anti-rheumatic, anti-inflammatory action of the most effective steroid, STERANE,® complemented by the superior central tranquilizing effects of ATARAX.® Minimal disturbance of fluid and electrolyte metabolism; no mental fogging or major toxicity in ataractic action.

FOR UNMATCHED RESPONSE AND MANAGEMENT IN RHEUMATOID ARTHRITIS... AS IN OTHER COLLAGEN DISEASES, BRONCHIAL ASTHMA, INFLAMMATORY DERMATOSES.

Supplied: Each green, scored ATARAXOID Tablet contains 5 mg. prednisolone (STERANE) and 10 mg. hydroxyzine hydrochloride (ATARAX). Bottles of 20 and 100.

PFIZER LABORATORIES
Division, Chas. Pfizer & Co., Inc.
Brooklyn 6, New York

Pfizer

*Trademark

Trasentine®-Phenobarbital

integrated relief . . .
mild sedation
visceral spasmolysis
mucosal analgesia

C I B A
Summit, N. J.

TABLETS ***(yellow, coated), each containing 50 mg. Trasentine® hydrochloride (adiphenine hydrochloride CIBA) and 20 mg. phenobarbital.***

2/222911

Say you saw it in the Journal of the Michigan State Medical Society

so much easier to use for dandruff

that patients can hardly fail to benefit...

SEBIZON

LOTION

simple as A-B-C, day or night routine

A—apply
B—rub in
C—brush off, or rinse off if desired

no complicated
shampoo or timing
procedures

effective in dry or oily dandruff

itching and stinging
scaling and crusting
oiliness of scalp

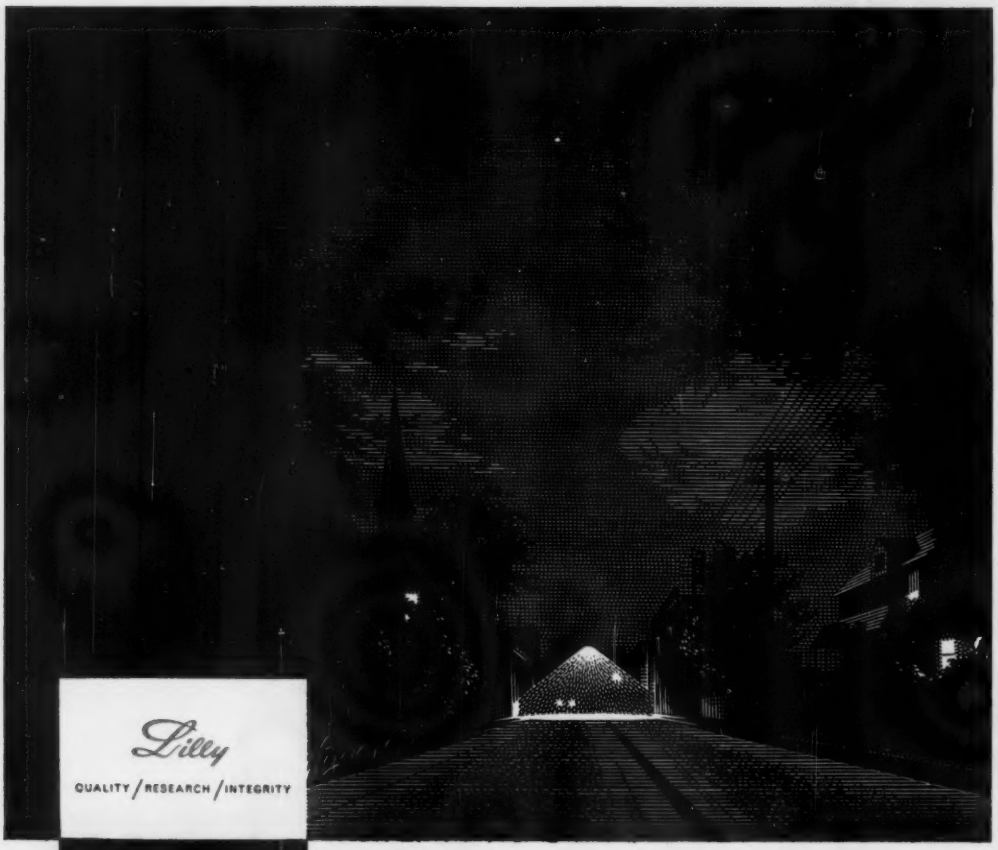
all respond quickly
to
SEBIZON

Available on Rx only in 3 oz. plastic squeeze tube.

SEBIZON,® (antiseborrheic preparation) contains
10% Sulfacetamide Sodium U. S. P.

Schering

SZ-J-117



for rapid yet sustained sedation

PULVULES

TUINAL

combine two cardinal features in a single preparation

There are equal parts of quick-acting 'Seconal Sodium'* and moderately long-acting 'Amytal Sodium'† in each Pulvule Tuinal. Assures your obstetric patient quick, sustained amnesia; your surgical patient relief from apprehension and fear.

*'Seconal Sodium' (Secobarbital Sodium, Lilly)
†'Amytal Sodium' (Amobarbital Sodium, Lilly)

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The JOURNAL

of the Michigan State Medical Society

Issued Monthly Under the Direction of The Council

VOLUME 56 MARCH, 1957 NUMBER 3

Perinatal Mortality Study in Wayne County

January, 1953, to July, 1954

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THE REALIZATION that neonatal mortality statistics have become fairly stable at levels of about 20 per 1,000 livebirths in the last ten years has stimulated a number of communities to organize surveys of the problem. In June, 1956, the Association of Maternal and Child Health Directors counted twenty-six states engaged in the study. The Wayne County Medical Society in collaboration with the Detroit and Michigan Departments of Health established its Perinatal Mortality Committee in 1952. A questionnaire type of report form was developed by a group of obstetricians, pediatricians, public health officers and pathologists. Approximately forty hospitals in Wayne County were asked to cooperate in completing a questionnaire for every stillbirth over 2,000 grams and all neonatal deaths. Nineteen agreed to do so.

Each cooperating hospital appointed a committee to review the reports, compiled by a resident or intern. The cause of death was to be verified and preventability assessed. These reports were then transmitted to the County Society Committee for further study. Ultimately all but nine hospitals discontinued this work. Preventability was too infrequently evaluated to analyze. No hospital reported one hundred per cent of eligible stillbirths and neonatal deaths as revealed by a check against death certificates. The average was 70 per cent with a range from 20 per cent to 88 per cent.

TABLE I. SUMMARY OF PERINATAL DEATHS ACCEPTED FOR ANALYSIS

Total Cases Studied		1,456
Cases Excluded—Stillbirths under 2,000 grams	87	
—No data	1	
Total Cases Accepted		1,368
Neonatal Deaths	943	
Stillbirths	425	

The pertinent maternal history, both medical and surgical, the history of the pregnancy, the labor and delivery, and the neonatal history were all to be covered in detail. The disease or condition leading directly to the infant's death as well as other antecedent causes and significant contributory conditions were reported with a reasonable degree of accuracy. However, at the time of statistical analysis, it became evident that there was frequent omission of other data, and numerous items had to be eliminated. Other items were loaded with nonpertinent information and also had to be discarded. For example, past medical history included tonsillectomy and nonrelated childhood diseases. This was a deficiency in editing by the central committee which must be corrected in future studies. Items regarding maternal anemia, abnormal vomiting, bleeding, and physiologic abnormalities were all inadequately recorded and specified.

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The number of cases studied as seen in Table I totaled 1,456, of which eight-eight were excluded, leaving 1,368. There were 943 neonatal deaths and 425 stillbirths. It is not our intention to prove any particular thesis in the study of these cases, but simply to subject these two groups, neonatal deaths and stillbirth, to statistical analysis, in order to document certain characteristics of perinatal mortality in association with maternal conditions.

A comparison was made of occurrence rate by cause to total stillbirths between stillbirths reported as occurring in the city of Detroit in 1954 and 1955 and the Perinatal Mortality Study. There was good matching in all cause groups listed in Table II except "maternal chronic disease" and "other." It is possible that the heavy weighting of the study group by Herman Kiefer Hospital cases has unduly influenced this group. Complicated maternity cases from the low income groups are generally routed through Kiefer Hospital. Otherwise, the comparison shows that the study group is a fair sampling of all stillbirths occurring in Detroit.

Another matching test was made for birth weight distribution of stillbirths as shown in Table IV. The two groups do not appear to be well matched. Discrepancies exist in three out of the

TABLE II. COMPARISON OF STILLBIRTHS ACCEPTED FOR STUDY WITH TOTAL STILLBIRTHS OCCURRING IN DETROIT DURING 1954-1955—CAUSES OF STILLBIRTH. (EXCLUDING ALL STILLBIRTHS UNDER 2,000 GRAMS)

Causes of Stillbirth	Detroit, 1954-1955		Perinatal Death Study	
	Number	% of Total	Number	% of Total
Maternal diabetes	37	2.4	21	5.0**
Other chronic disease in the mother	19	1.2	7	1.6
Acute infection in mother	5	0.3	4	1.0
Toxemia	97	6.2	30	7.1
Ante-and intra-partum infection, etc.	10	0.6	6	1.4
CPD, dystocia, and malposition	95	6.1	22	5.2
Cord and placental conditions				
Cord	309	19.7	69	16.2
Placental conditions	301	19.3	86	20.2
Birth injuries	27	1.7	11	2.6
Congenital malformation	112	7.2	32	7.5
Asphyxia; immaturity; unknown	391	25.0	94	22.1
Erythroblastosis	87	5.6	34	8.0
Other	73	4.7	9	2.1*

*Significant at 5% level.
**Significant at 1% level.
A greater proportion of women having some chronic disease as a cause of stillbirth exists in the study group in the city stillbirth occurrence. This may be due to the large proportion of cases selected from Herman Kiefer Hospital. Many problem cases are referred to Herman Kiefer Hospital for obstetrical care and follow-up.

TABLE III. COMPARISON OF NEONATAL DEATHS ACCEPTED FOR STUDY WITH TOTAL NEONATAL DEATHS OCCURRING IN DETROIT DURING 1953-1955—CAUSES OF DEATH

Cause of Death	Detroit, 1953-1955		Perinatal Death Study	
	Number	% of Total	Number	% of Total
Congenital malformations—CNS	40	1.2	13	1.3
Congenital malformations—Circul. Syst.	135	4.2	37	3.9
Other congenital malformations	171	5.3	71	7.5**
Birth injuries	244	7.6	83	8.8
Postnatal asph. and atelectasis	890	27.5	328	34.8**
Infections of newborn and other infections	105	3.2	20	2.1
Hemolytic disease of newborn	120	3.7	17	1.8**
Immaturity	1451	44.8	342	36.4**
Other	80	2.5	32	3.4
Total	3236		943	

**Significant at the 1% level.
1. Greater proportion of congenital malformations in study group than for city.
2. Greater proportion of asphyxia and smaller proportion of immaturity as cause of death in study group than for city as a whole. This is due to greater care in certifying other than immaturity as a cause of neonatal death. Unfortunately, asphyxia and atelectasis is, in itself, as great a wastebasket cause as is immaturity. It is more descriptive of the mode of dying than a cause of death. This points out the need for establishing a new series of death cause classes pointing out abnormalities in delivery, pathology in the mother leading to abnormal gestation and delivery, etc.
3. A lower proportion of deaths due to erythroblastosis exists in the study group than in the deaths occurring in the city. This may be due to the heavy weighting of cases from Herman Kiefer Hospital, where the majority of the patients are drawn from the Negro race. The incidence of Rh negative individuals is extremely small in the Negro.

seven groups: 2,521 to 2,725 grams, 3,626 to 4,080 grams, and 4081 plus. There are a large number of stillbirths reported to the Bureau of Vital Statistics where weight is not stated. This is a deficiency in hospital reporting of stillbirths and points out the need for further education of delivery room personnel to weigh all stillbirths.

Table V shows better sampling as evidenced by birth weight distribution in neonatal deaths when the study group is compared with death certificates for the city at large. There is significant difference only in infants less than 1390 grams and weights not stated. The failure to weigh infants is greater in the city as a whole than in the

TABLE IV. COMPARISON OF STILLBIRTHS ACCEPTED FOR STUDY WITH TOTAL STILLBIRTHS OCCURRING IN DETROIT DURING 1954-1955— BIRTH WEIGHTS (EXCLUDING ALL STILLBIRTHS UNDER 2,000 GRAMS)

	Birth Weights in Grams							
	2071-2300	2301-2520	2521-2725	2726-3175	3176-3625	3626-4080	4081+	Not Stated or Unknown
Detroit perinatal death study	8.2	9.4	10.1**	24.3	16.2	11.5**	11.3**	9.0
Detroit occurrence 1954, 1955	10.5	10.6	5.2	22.4	19.5	16.4	6.7	12.5

**Significant at 1% level

TABLE V. COMPARISON OF NEONATAL DEATHS ACCEPTED FOR STUDY WITH TOTAL NEONATAL DEATHS OCCURRING IN DETROIT DURING 1953-1955— BIRTH WEIGHTS

	Birth Weights in Grams										
	Under 1390	1390-1615	1616-1840	1841-2070	2071-2300	2301-2520	2521-2725	2726-3175	3176-3625	3626-4080	4081+	Not Stated or Unknown
Detroit perinatal death study	53.3**	6.2	6.0	4.1	3.8	3.1	3.4	6.7	6.2	2.5	1.8	2.9**
Detroit occurrence 1954, 1955	43.1	5.9	5.3	3.9	3.7	3.6	2.4	7.3	6.2	2.7	1.7	14.2

**Significant at 1% level.
Many infants were not weighed at birth. Birth weight was estimated for study or obtained from autopsy report after birth certificates (from which weight data were transcribed to death certificates) were turned in to Registrar. The differences seen here, then, have no real meaning.

TABLE VI. COMPARISON OF CONDITIONS IN MOTHER AND INFANT FOR LIVEBORN INFANTS DYING IN THE NEONATAL PERIOD AND FOR STILLBORN INFANTS

	Maternal and Infant Pathology Present				
	Liveborn-Neonatal Death		Stillbirth		
	Number	Percent	Number	Percent	
Total studied	943	100.0	425	100.0	
Pelvic or abdominal surgery	182	19.3	83	19.5	Surgery recorded which was not pertinent
Abnormal vomiting	109	11.6	32	7.5*	
Bleeding	275	29.2	68	16.0**	
Hypertension	74	7.9	60	14.1**	
Albuminuria	67	7.1	56	13.2**	
Infections	27	2.9	12	2.8	
German measles or other virus	12	1.3	4	0.9	
Medical or surgerical complications	106	11.3	72	17.0	Many conditions, not appropriate, included
Anemia	94	10.0	49	11.5	
Multiple pregnancy	126	13.4	11	2.6**	
Premature rupture of the membrane	102	10.8	32	7.5	
Analgesia	496	52.7	311	73.2**	
Pituitrin	59	6.3	64	15.1**	
Jaundice	43	4.6	4	0.9	

A greater number of women having liveborn infants:
1—had a history of abnormal vomiting
2—had a history of bleeding during pregnancy
3—had a multiple pregnancy

Fewer women having liveborn infants:
1—had hypertension or albuminuria
2—received analgesia or pituitrin

*Significant at 5% level.
**Significant at 1% level.

study group. This indicates that case reviews result in greater attention to detail in hospitals and are beneficial for that reason if for no other.

as they appear in stillbirth and neonatal death records. Table VI lists the number and percentage of each group which shows the condition

TABLE VII. CAUSE OF STILLBIRTH AND GRAVIDA (EXCLUDING GRAVIDA UNKNOWN OR NOT STATED)

Cause	Gravida											
	Median	1	2	3	4	5	6	7	8	9	10+	Total
Chronic disease in mother	4.38	6	2	3	2	4	4	2	1	1	3	28
Maternal toxemia	3.62	10	0	3	4	5	1	1	3	2	1	30
Dystocia and birth injury	1.92	11	6	5	2	6	0	1	0	1	0	32
Cord condition	2.14	22	11	7	11	7	2	2	1	0	4	67
Placental condition	2.35	21	17	13	16	9	3	2	1	1	1	84
Congenital malformation	1.83	9	9	7	5	0	1	0	0	1	0	32
Erythroblastosis	3.36	2	4	9	7	4	3	1	4	0	0	34
Immaturity and asphyxia	2.32	22	19	19	13	7	7	1	1	2	2	93
Other	3.33	5	1	3	3	3	2	0	0	0	2	19
Total	2.48	108	69	69	63	45	23	10	11	8	13	419
Percent		25.8	16.5	16.5	15.0	10.7	5.5	2.4	2.6	1.0	3.1	
Accumulated percent			42.3	58.8	73.8	84.5	90.0	92.4	95.0	96.9		

Women delivering stillbirths have a history of a greater number of pregnancies than women delivering liveborn infants who die during the neonatal period. Comparing gravidity and parity, a greater fetal loss per number of pregnancies is seen for the following causes of stillbirth:
Dystocia and birth injury
Cord conditions
Immaturity and asphyxia

TABLE VIII. CAUSE OF STILLBIRTH AND PARITY (EXCLUDING PARITY UNKNOWN OR NOT STATED)

Cause	Para											
	Median	0	1	2	3	4	5	6	7	8	9	10+	Total
Chronic disease in mother	3.08	5	5	3	1	6	3	1	1	2	1	0	28
Maternal toxemia	2.50	10	2	2	3	4	1	4	2	1	0	1	30
Dystocia and birth injury	0.33	16	3	5	2	4	1	1	0	1	0	0	33
Cord condition	0.88	19	17	7	10	7	1	2	1	1	0	2	67
Placental condition	1.26	23	15	17	16	8	3	0	1	1	0	0	84
Congenital malformation	0.68	9	11	7	2	2	0	0	1	0	0	0	32
Erythroblastosis	2.25	2	4	10	6	8	0	3	1	0	0	0	34
Immaturity and asphyxia	0.93	21	28	17	12	6	3	1	1	2	0	2	93
Other	2.20	5	2	2	5	2	1	0	0	0	2	0	19
Total	1.19	110	87	70	57	47	13	12	8	8	3	5	420
Percent		26.2	20.7	16.7	13.6	11.2	3.1	2.8	1.9	1.9	0.7	1.2	
Accumulated percent			46.9	63.6	77.2	88.4	91.5	94.3	96.2	98.1	98.8		

Women delivering stillbirths have a history of a greater number of previous deliveries than women delivering liveborn infants who die during the neonatal period.

TABLE IX. NEONATAL DEATH CAUSE AND GRAVIDA (EXCLUDING GRAVIDA UNKNOWN OR NOT STATED)

Cause	Gravida											
	Median	1	2	3	4	5	6	7	8	9	10+	Total
Congenital malformation	1.94	27	34	27	17	6	3	1	2	0	0	117
Birth injury	1.64	28	21	11	5	8	3	4	1	0	1	82
Asphyxia	2.13	71	82	61	45	21	16	4	10	4	7	321
Infection	1.80	6	5	2	2	0	0	2	0	0	2	19
Hemolytic disease of newborn	3.50	3	2	3	2	2	3	1	1	0	0	17
Immaturity	2.11	87	75	70	42	28	18	8	4	4	3	339
Other	1.67	10	9	3	5	1	1	1	1	0	0	31
Total	2.01	232	230	176	118	67	44	21	19	8	13	928
Percent		25.0	24.8	18.9	12.7	7.2	4.7	2.3	2.1	0.9	1.4	
Accumulated percent			49.8	68.7	81.4	88.6	93.3	95.6	97.7	98.6		

Comparing gravidity and parity, a greater fetal loss per number of pregnancies is seen for the following causes of death:
Asphyxia
Immaturity

The table shows that the study cases represent a fair sample of the universe of neonatal deaths in the city of Detroit.

A comparison was made of maternal conditions under study. It appears that a greater number of women having liveborn infants had a history of abnormal vomiting, bleeding during pregnancy and multiple pregnancies. We have no interpre-

tation for the abnormal vomiting and bleeding, but it is not difficult to see that the product of multiple pregnancies, while often low in weight, are quite apt to be born alive, albeit with a poor chance for survival.

Fewer women having liveborn infants had hypertension or albuminuria and fewer received analgesia or pituitrin. The possible effects of toxemic factors or depressing agents in producing stillbirth reveals itself here.

Tables VII through XI relate stillbirths to gravidity, parity and previous abnormal pregnancies. Women delivering stillbirths have a history of a greater number of pregnancies than those delivering livebirths who die in the neonatal period. The difference between parity and gravidity in the dystocia and birth injury stillbirths indicates that women delivering stillbirths due to that cause had a history of greater fetal loss than mothers of other stillbirths. Women delivering stillbirths have a history of a greater number of births than do those delivering liveborn infants dying during the neonatal period. In the neonatal death group the differences between parity and gravidity in the asphyxia and immaturity deaths indicates that women delivering infants who die of these causes had a history of greater fetal loss than mothers of infants dying of any other cause.

Table XII shows the incidence of various forms of anesthesia related to stillbirths and neonatal deaths. There was less pudendal usage in the stillbirth class than in the neonatal deaths. Here,

TABLE X. NEONATAL DEATH CAUSE AND PARITY (EXCLUDING PARITY UNKNOWN OR NOT STATED)

Cause	Para												
	Median	0	1	2	3	4	5	6	7	8	9	10+	Total
Congenital malformation	0.99	18	42	32	11	9	1	3	1	1	0	0	118
Birth injury	0.70	26	22	16	5	6	4	3	0	0	0	0	82
Asphyxia	0.76	91	92	52	35	23	10	11	4	0	0	2	320
Infection	0.75	7	4	3	2	0	2	0	0	0	0	1	19
Hemolytic diesease of newborn	2.5	2	3	3	2	3	3	1	0	0	0	0	17
Immaturity	0.71	110	83	72	30	17	15	2	5	1	2	0	337
Other	0.64	9	11	4	5	0	0	1	1	0	0	0	31
Total	0.78	263	257	182	90	58	35	21	11	2	2	3	924
Percent		28.4	27.8	19.7	9.8	6.3	3.8	2.3	1.2	0.2	0.2	0.3	
Accumulated percent			56.2	75.9	85.7	92.0	95.8	98.1	99.3	99.5	99.7		

TABLE XI. HISTORY OF PREVIOUS ABORTIONS, IMMATURES, OR OTHER ABNORMAL PREGNANCIES FOR WOMEN DELIVERING STILLBORN AND LIVEBORN INFANTS AS PERCENT OF TOTAL CASES*

	Previous Abortions							
	None	1	2	3	4	5	6+	Total
Stillborn	75.3	17.7	3.9	1.9	1.0	0.2	0.0	413
Liveborn-neonatal death	86.0	11.1	1.8	1.1	0.0	0.0	0.0	280

The two groups differ significantly. Women delivering stillbirths have a history of a greater number of abortions.

	Previous Immatures							
	None	1	2	3	4	5	6+	Total
Stillborn	90.4	7.4	1.5	0.0	0.5	0.2	0.0	404
Liveborn-neonatal death	90.3	8.5	0.4	0.4	0.0	0.0	0.4	282

The two groups do not differ materially regarding number of previous immatures.

	Previous Other Abnormal Pregnancies							
	None	1	2	3	4	5	6+	Total
Stillborn	85.4	11.7	2.2	0.5	0.0	0.2		410
Liveborn-neonatal death	86.1	11.3	2.1	0.5				278

The two groups do not differ materially regarding number of previous abnormal pregnancies.
*Unknown or not recorded cases excluded; Liveborn 2,000 grams and under excluded, to match groups.

TABLE XII. ANESTHESIA USED FOR DELIVERY—COMPARING STILLBIRTHS AND NEONATAL DEATHS

	Anesthesia						
	Pudendal	Saddle	Spinal	Inhalation	Other	None	Total
Stillbirths —number	30	14	55	237	12	77	425
—percent	7.1**	3.3	12.9	55.8**	2.8	18.1**	
Neonatal Deaths —number	105	55	142	350	20	271	943
—percent	11.1	5.8	15.1	37.1	2.1	28.8	

**Significant at 1% Level
Fewer women delivering stillbirths had pudendal or no anesthesia. More women delivering stillbirths had inhalation anesthesia.

TABLE XIII. ANALGESIA AND ANESTHESIA USED FOR DELIVERY. STUDY OF A SELECTED GROUP OF CASES

	Stillbirths			Neonatal Deaths		
No Analgesia or Anesthesia		5	8.8%		32	19.9%
Analgesia alone		3	5.3%		3	0.9%
Analgesia—total		47**	82.5%		92	57.2%
—with barbiturates	7			25		
—without barbiturates	40			67		
Analgesia and Anesthesia		44**	77.3%		80	55.4%
Analgesia and Inhalation Anesthesia	23			46		
Analgesia and Conduction Anesthesia	21			43		
Anesthesia Alone—Total		5	8.8%		37	23.0%
Anesthesia Alone—Inhalation	4			15		
Anesthesia Alone—Conduction	1			22		
Ether		27a	54.0%		54a	42.5%
No Ether		23	46.0%		73	57.5%
Total cases includedb in Anesthesia and Analgesia Study		57			161	

**Significant at 1% level
(a) One in each group was recorded as "ether analgesia"
(b) Infants or stillbirths were included in this phase of the study who:
1. Had no conditions which might be considered incompatible with life. These include congenital anomalies, erythroblastosis, or who to match the stillbirths, were under 2,000 grams.
2. Were not macerated stillbirths and were known to have been alive until shortly before birth.
3. Did not have serious maternal or birth complications. Excluded were deaths occurring because of: a) Toxemia, diabetes, or CV disease; b) Placental or cord problem; c) Difficult labor, presentation or inertia.

especially, a group of controls of survivors would have been valuable to see if this is a trend in the direction of survival with this form of anesthesia. The opposite situation is seen under inhalation anesthesia, where there are more stillbirths under that class. With no anesthesia the apparent trend is similar to pudendal. A control group of survivals is necessary for verification of these differences.

Table XIII shows a comparison of analgesia and anesthesia in varying combinations between stillbirths and neonatal deaths. In order to minimize the effects of other factors, we eliminated infants or stillbirths who had conditions which might be considered incompatible with life such as congenital anomalies and erythroblastosis. To match the two groups we eliminated neonatal deaths under 2000 grams. We included only nonmacerated stillbirths known to have been alive until shortly before birth. Also eliminated were those infants with serious maternal or birth complications such as toxemia, diabetes, cardiovascular disease, placental or cord problems, difficult labor, presentation or inertia.

Analgesia, both with and without anesthesia, shows a significant difference between the stillbirths and neonatal deaths. There is a greater usage of analgesia, proportionately, in the stillbirths than in the neonatal deaths. Here, too, a control group would have strengthened the validity of this observation.

Conclusions

1. A second Perinatal Mortality Study should be instituted with a new approach, using a check sheet report of the type devised by the North Carolina State Board of Health and other groups.

2. A research staff is needed with a substantial part of its time available for supervision, completion and editing, to produce reliable data. This staff should also be available to participating hospitals in organizing their programs. It should co-ordinate the efforts of the hospital committees with the Wayne County Medical Society Perinatal Mortality Committee. In order to resume this study in keeping with these recommendations, it will be necessary to provide a research grant for the purpose of financing the special staff needed to do the work. The nucleus of this staff might be composed of an obstetrician-pediatrician team; clerical, nursing and statistical services co-ordinated by an epidemiologist who would serve as the research director.

3. A random selection of surviving infants should be made to serve as a control against the perinatal deaths.

4. Regular review of all perinatal deaths in all hospitals in Wayne County should be established procedure for accreditation. Without any deliberate evaluation it is evident from this study that the examination of perinatal deaths resulted in more careful attention to certain details. The educational results should produce at least some beneficial effect on fetal and neonatal salvage.

5. An evaluation of factors of preventability should be part of future study.

(Continued on Page 330)

Review of Immunization Programs Recommended With Advent of Salk Vaccine

By James L. Wilson, M.D.
Ann Arbor, Michigan

IT is clear that immunization against poliomyelitis should now be routine and must be integrated with other immunization procedures. Now, therefore, is a good time to review our present habits of immunization in this part of the country, and to consider why we have arrived at our present generally accepted program.

Immunization is routine against diphtheria, whooping cough, tetanus, and smallpox in Michigan, and now poliomyelitis must be attacked. We may hope that in a few years other diseases can be prevented; for instance, measles.

Our present programs, like many other things in medicine, are a result of multiple compromises. In considering the acceptance of any immunizing agent, the factors to be weighed are the effectiveness of the immunizing agent balanced against the risk of the procedure, and all considered in balance with the risk of the disease itself. The risk of the disease itself may change over the years as is true to these common diseases which are being considered. The risk is influenced by the frequency of the disease and, of course, by the effectiveness of available treatment.

The timing of the procedure is first determined by the danger period in life of the disease considered, but our whole program is of course greatly influenced by matters of convenience and cost. There has been in the last decade a marked trend towards early immunization so that most routines are initiated in very young children, at two or three months of age or even earlier. This tendency has developed because of the convenience of immunizing small infants, the short memory of a three-month-old infant, the few reactions, but most importantly the desire to develop, early in life, protective antibody levels against whooping cough.

The first disease against which general immunization was successful was, of course, smallpox. Here in Michigan, and at this time, we can consider that we are carrying out smallpox vaccination on an individual as a matter of general duty to the public. The risk of exposure to smallpox itself is almost negligible. The risk of serious complications from the vaccination is very small indeed, but even local reactions are a nuisance so that we can consider that a person living in Michigan at present is making some sacrifice for the good of general public health by having his infant or himself vaccinated. We realize, however, that if this procedure were dropped, we probably would be in trouble again in a very few years and no one questions the advisability of continuing smallpox vaccination. The age of vaccination becomes then surely a matter of convenience since the risk of exposure at any age is small. It is obvious that the risk of the vaccination procedure itself becomes somewhat less in the small infant than the child of two or three, since he is less likely to contaminate the vaccination wound with his fingers when he is an infant. He is more protected and there is less chance for secondary infection. Another argument for early immunization is that the infant is much more under our control; we have him in our hands, as it were, and early vaccination can be combined with vaccination for other diseases for which the urgency is somewhat greater. Most physicians, therefore, are combining the vaccination with the other immunizations and a convenient time is in the middle of the first year. Some physicians are recommending smallpox vaccination in the newborn period. It is true that almost every baby is then completely under control since he is in the hospital and vaccination can be recommended then with certainty that it is going to be accomplished. The disadvantage is worth considering. There probably are a greater number of failures of "takes" in the newborn period. There seems to be some lessening of ability to develop vaccinia and, of course, many physicians dislike complicating this very confused period of life with some other illness. However, it is clear that the decision as to when to vaccinate can be made on the

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basis of convenience rather than on immunological data.

It was early believed that a very young baby developed antibodies against pertussis very poorly, so in the early days of pertussis immunization the procedure was not initiated until the child was six, seven, or even eight months of age. In the case of pertussis this delayed immunization carried a very great disadvantage since the mortality from whooping cough is far greater in early infancy than it is later. It was a great step ahead when Sako* showed that a small baby could indeed make antibodies to pertussis, even though not as effectively. There was an immediate trend towards earlier immunization against pertussis to gain some protection as soon as possible against higher mortality in early infancy. This was very reasonable, even though the antibody level resulting might not be as great. Whether this should be initiated at one month, two months, or three months, is still a matter of opinion but that it should be early seems definitely accepted by everyone. It is interesting that soon after we began the early immunization against whooping cough for the advantage it gave us in the prevention of early and highly fatal disease in small infants, our antibiotics began to appear and the risk of whooping cough itself in early life became less if medical care was sought since our treatment became immediately more effective. Nevertheless, there seems no reason at all to return to the late date of immunization simply because we have these broad spectrum antibiotics.

About the time when the effectiveness of early initiation of whooping cough vaccination became evident the combinations of antigens such as whooping cough and diphtheria were shown to be effective. We feel, however, no urgency to immunize the small infant against diphtheria. Maternal antibodies are carried through the placenta and this passive immunity protects the baby pretty effectively for six months or so. However, the advantage of the combination of diphtheria toxoid and pertussis vaccine made it practical and sensible to give the diphtheria toxoid early simply because we needed to get pertussis immunity early.

Immunization against tetanus has almost always been a "free rider" in the pediatric age group. The risk of tetanus in infancy is practically negligible. We immunize our infants against tetanus not so much because of the risk from tetanus as that it can be done "for nothing" since it can be combined very effectively with diphtheria and whooping cough with some synergistic advantage and no added risk of reaction.

In our more sophisticated populations the advantage of immunization against tetanus is as much to prevent the later need for decision about giving horse serum with its risks in case of an accident as it is simply to prevent tetanus. Immunization against tetanus had never been proved by clinical data to be effective in infants or young children. However, the determination of antibody level showed, without any question, that immunization was theoretically effective. It remained for war experience in adults, however, to prove from a clinical point of view that tetanus immunization with the use of toxoid actually was effective, and no one questions the advisability of combining it, therefore, with the other agents in the now common triple vaccine, whooping cough and diphtheria, all at an early age as a matter of convenience rather than because the risks in these early months of life calls for such protection.

Now, the new agent, the Salk vaccine, comes in for consideration. There is no need in this note to attempt to summarize the results of the nationwide experiment which was necessary to determine the effectiveness of the Salk vaccine. We can accept it as being highly effective even though we are not yet quite certain as to how frequently booster shots have to be given. In the great experiment, the shortage of the material available made it practical to limit the immunization to the children in the age group where the greatest poliomyelitis incidence occurred, and where the children were available for controlled experiment, that is, in the first, second, and third grade children. After the vaccine was shown to be effective, there was still a great shortage of the vaccine which only recently has been relieved, so that immunization continued for some time to be restricted to the most susceptible age groups, excluding infants.

As with all immunization procedures, again the question arose as to the ability of a small infant to develop antibodies under the stimulus of an antigen. This was questioned in regard to poliomyelitis as it had been in regard to whooping cough and other diseases, but particularly because of the known passive immunity which the mother

*The Journal of the American Medical Association Vol. 127, No. 7, February 17, 1945, page 379.

transmitted to the baby, as in diphtheria, which protected the baby for a considerable extent, though not absolutely, for the first early months of life. The question was whether the passive immunity of early life might prevent the development of active immunity, and whether the small infant's capacity to develop antibodies was too immature anyway. It was a big step ahead therefore, when it became pretty evident that the presence of passive antibodies did not prevent the development of active antibodies, but this did not prove still that young babies could, in fact, develop antibodies. At this moment, only a few studies have been carried out on this point. The one from the Well Baby Clinic of the Michigan School of Public Health and Department of Pediatrics has seemed to us adequate, however, to establish the fact that a useful level of antibodies can be produced in this age group. It seems certain, at this writing, that immunization can be initiated at three or four months of age or even earlier without the antigen's being wasted.

Now, although the risk of poliomyelitis is very much less in small infants than in older children, the convenience of injecting a small infant versus an older child, again adds its weight to the argument for early immunization. The fact that the babies are being routinely brought by their mothers to physicians for such procedures, gives another reason for initiating the immunization then rather than waiting for the age group where the risk of poliomyelitis is greater.

There seems at present to be no reason for not giving the Salk vaccine at the same time we initiate the so-called triple vaccine injections. A question still at issue is whether the mixing of the Salk vaccine and the standard triple vaccine in the same syringe results in any less effectiveness of the two agents. The fact that the State furnishes free one material, and the other must be purchased, also may pose a small problem. It seems best to give the two products separately in two syringes until further data are available, though probably the mixture would be both safe and effective.

There has been much public discussion of the advantage of an oral vaccine against poliomyelitis. This procedure is indeed tempting to consider. It seems highly probable that such a vaccine can be developed and may be available in a few years, and it appeals to us because the oral route is the way that nature itself produces natural immunizations, and because it could be given without the pain and the bother associated with a needle. However, the advantage of an oral vaccine, if available, over our injected vaccine may not be very great from a practical point of view if the vaccine can be combined with the present triple vaccine into a quadruple vaccine. Can such a package be made of the four vaccines? I think there is little doubt that it can be and that we can expect soon such product to be on the market, but possibly not approved for one or two years, though very active work is being carried on in this field. When this takes place, the advantage of an oral vaccine in infants will then become negligible since we have to give a "shot" anyway for the routine immunization against our other diseases, and the combination of the Salk vaccine, like that of tetanus, can be a "free rider" with the other necessary immunization procedures. But without waiting for an oral vaccine or a quadruple vaccine, and with the availability of an adequate supply of Salk vaccine, it seems desirable that immunization with the Salk vaccine in infancy should be immediately carried out as a routine. The administration of two shots at the same time is very convenient indeed. A small baby hardly begins to cry from his first shot before the second one is injected, and the total trauma to be remembered, therefore, seems to be actually about the same as if the product were mixed.

The timing of the procedure again seems to be a matter of convenience. The baby is brought to most physicians at two or three months of age for initiation of the triple vaccine. A very practical procedure, therefore, is to begin now to give two shots at three months (or if one prefers at two months), one of the triple vaccine, which is now traditional and free, and one of the Salk vaccine that must be purchased; on the fourth month of life, or one month after the first shot, to give again the triple vaccine; on the fifth month to give the third shot of the triple vaccine, as we now do, and the second shot of the Salk vaccine, and finally the third shot of the Salk vaccine with the routine booster shot of the triple vaccine at the end of the first year or some few months later. The reactions to Salk vaccine have been so small that the fear of a double reaction, therefore, seems no longer an adequate reason for wanting to give

the two shots at different times. The total amount of work involved for the physician is hardly increased. Since the total amount of work for the mother to bring her child to a physician for this procedure is not increased, she is likely, therefore, to adhere to the program.

The booster shot is now routine and is wisely based upon the fact that although immunization when it is started as early as three months, may result in somewhat less effective production of antibodies, that a booster shot will bring on a marked recall reaction and give us a total immunity far better than if we had started it later with only three injections. One must not consider the proposed program as necessarily to be rigidly followed because great variations of it might well be made without theoretical disadvantage.

There is some question whether the initiation of Salk vaccine immunization should ever be coincidental with a booster shot to other agents. *The Journal of Immunology** has published some data that would indicate that there may be a poor response to the first injection of one antigen if, at the same time there is being stimulated a recall reaction by a "booster shot" of some other antigen. In other words, a recall reaction to tetanus, pertussis, and diphtheria by a booster shot being given, let us say at fifteen months, might be a poor time to give the first shot of the Salk vaccine. This is another reason, therefore, to initiate them all simultaneously.

*_The Journal of Immunology_—Volume 77, Number 3, September, 1956. Studies on Diphtheria-Pertussis-Tetanus Combined Immunization in Children. I. Heterologous Interference of Pertussis Agglutinin and Tetanus Antitoxin Response by Pre-existing Latent Diphtheria Immunity.

The infant immunization program has been carried out by pediatricians with such enormous success that the vast majority of people, taught to expect this program, are cooperating to have their infants so protected, but this interest in little babies does not seem to be carried on to the school age group. The lack of interest in maintaining protection of older children against diphtheria, for instance, has been emphasized recently by the increase of diphtheria cases in Detroit. It is rather disturbing that now that there is an abundance of Salk vaccine, the demand by the public for it has become less. We shall have to "sell" this protection to the people now, just as we have less dramatized procedures in the past. The problem of getting adults immunized, and older children who are already past the childhood age in which immunization procedures is associated in the public mind, is a very difficult one. The initiation of a Salk vaccine procedure in an infant, however, makes a very good time to suggest to young parents that they themselves could profit from this protection as the data year by year show more and more the increased age incidence of poliomyelitis.

The following is a suggested program to be followed now until a quadruple vaccine is available. It should be emphasized that theory would permit wide variations in any program and that practical considerations of convenience, cost, and of the public interest, play a bigger part of establishing the details than do immunization principles.

3rd month—triple vaccine and 1st Salk dose
4th month—triple vaccine
5th month—triple vaccine and 2nd Salk dose
15-18th month—triple vaccine and 3rd Salk dose

PERINATAL MORTALITY STUDY IN WAYNE COUNTY

(Continued from Page 326)

6. An "alerter" system might be efficiently used to investigate current perinatal mortality rates in hospitals where they deviate from the expected mean. This need not be so elaborate as the Chicago system.

7. The Association of Obstetricians and Gynecologists, the American Academy of Pediatrics and other interested organizations should meet with representatives of the statistical division of the World Health Organization to revise the section of the international lists of Diseases and Causes of Death which pertain to perinatal mortality. In coding stillbirths, there is too much overlapping of asphyxia and immaturity. On the other hand, there is inadequate coding of maternal complications in neonatal deaths.

A Review of Pediatric Meningitis in a General Hospital Over a Ten-Year Period

By E. M. Eichhorn, M.D.
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OVER THE past two decades the outlook for the meningitis patient has changed from one of almost complete hopelessness to that of fairly good chance for complete cure. However, deaths and disabling complications from meningitis still occur, and the disease remains a sufficiently formidible emergency to warrant serious study for the purpose of improving our understanding of the disease and thereby utilize our diagnostic and therapeutic weapons to best advantage.

Of the many advances in clinical medicine during recent decades, none surpass antimicrobial therapy in usefulness to the practitioner of medicine in his efforts to control disease. Nowhere is the importance of antimicrobial agents more dramatically portrayed than in the therapy of meningitis. Now that most of the commonly used antimicrobials have been available for several years, it is possible to study the results of their use. The purpose of this study is to determine how effective their use has been in the past, and to find if previous experience offers information enabling us to utilize them more effectively.

The material for this study was provided by reviewing the case records of pediatric meningitis cases from 1945 through 1954 at Hurley Hospital. We feel that Hurley Hospital, a general hospital with an open staff, offers an excellent opportunity to examine the care of a serious infectious disease by a presumably average cross section of medical practitioners.

Over the ten-year-period there were 151 cases with thirty-four deaths, for a gross mortality rate of 22.5 per cent. When the statistics are examined for individual years (Fig. 1), it is found that there is a gradual increase in the number of cases, while the death rate follows a downward trend. The mortality for recent years approaches the 10 per cent rate which should be obtainable, according to recent articles.[1,2]

Of the patients who survived their illness, sixteen (14 per cent) were noted to have definite neurologic residuals. These included mental retardation, paralysis, spasticity, convulsions, hydrocephalus and blindness. One can assume that not all residuals became fully documented on the

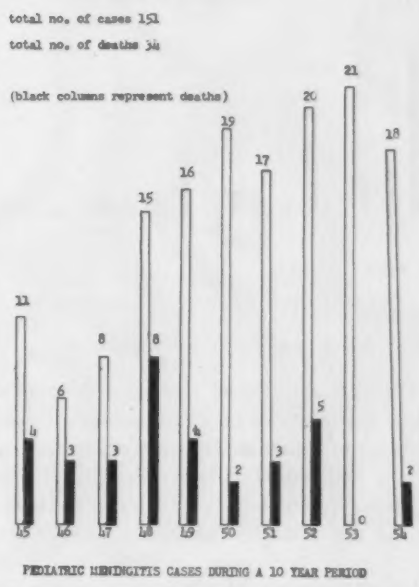

Fig. 1. Pediatric meningitis cases during a ten-year period.

charts. Subtle damage resulting in personality changes, behavior problems, mild retardation, and mild spasticity could easily be overlooked in an infant. In addition, there were twenty-two cases with periods of hospitalization over three weeks. Such prolonged courses would imply late control of the disease and a high incidence of residual brain damage.

Figure 2 demonstrates the age incidence and the death rate according to age. Of the nine infants less than one month old, eight died. Of the twenty-nine infants one to six months old, seven died. It is obvious that meningitis is primarily a disease of infancy and that mortality is higher in the very young.

Clinical Manifestations

To prevent mortality and to keep residual central nervous system damage at a minimum, early recognition is essential. In an effort to become

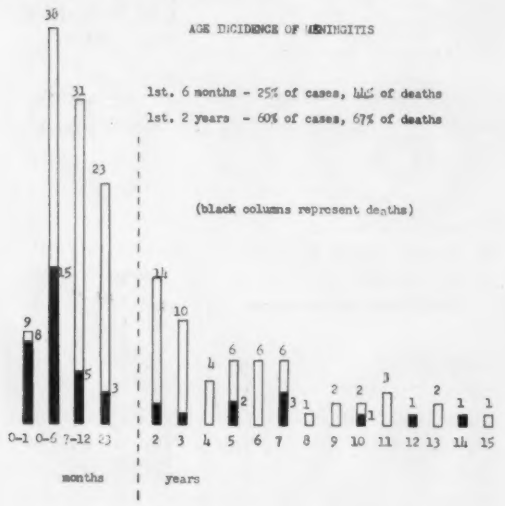

Fig. 2. Age incidence of meningitis.

familiar with the clinical findings seen most frequently, the observations on the patients reviewed were listed in Table I. This tabulation consists of the signs and symptoms noted on the 115 cases with an acceptable history and physical examination. All age groups were included. It is interesting that in twenty-six cases no mention was made of the presence of the findings usually associated with meningeal irritation. These cases were reported as having the findings shown in Table II. As might be expected, most of these patients were in the younger age groups, however; the oldest was twelve years old. It is noteworthy that ten of the twenty-six patients expired. Frequently, diagnosis was not suspected early and proper therapy was delayed.

It is only reasonable to assume that if those who examined these patients had been more familiar with the less well known manifestations of meningitis in infancy, the tabulation would have been higher for these findings. An excellent review article published recently[1] listed the more common findings seen in meningitis at different stages of infancy. These are presented in Table III.

In reviewing the clinical picture of meningitis, it is useful to remember that most cases are hematogenous in origin.[3] If the septicemia can be recognized and treated before meningitis appears, the prognosis becomes much better. In septicemia, as well as in meningitis, clinical manifestations in the newborn and younger infant are not as striking as in older children, and valid information regarding these manifestations is valuable. Table IV contains manifestations listed in a report recently published.[4] The authors reported that enteric organisms were found in 80 per cent of cases in recent years, with *Escherichia coli* the most frequently encountered organism.

TABLE I. SYMPTOMS AND SIGNS OF MENINGITIS (FROM 115 CASES WITH ADEQUATE WORK-UP)

FEVER	85
STIFF NECK	77
VOMITING	70
DROWSINESS	49
RASH-PETECHIA	28
CONVULSIONS	26
STIFF BACK	23
UPPER RESPIRATORY INFECTION	21
HEADACHE	18
COMA	15
IRRITABLE	14
BULGING FONTANELLE	10
OCULAR SIGNS	7
NECK PAIN	7
KERNIG, BRUDZINSKI	4
LEG PAIN	3
BACK PAIN	2
ABDOMINAL PAIN	2

TABLE II. SIGNS AND SYMPTOMS IN 26 CASES WITHOUT MENINGEAL IRRITATION

FEVER	19
VOMITING	15
DROWSINESS	14
CONVULSIONS	7
BULGING FONTANELLE	6
RASH OR PETECHIA	6
COMA	4
UPPER RESPIRATORY INFECTION	4
IRRITABILITY	3
HEADACHE	2
OCULAR SIGNS	2

Laboratory Diagnosis

Once meningitis (or septicemia in infants) is suspected, the spinal fluid should be examined as soon as possible. By personally examining spinal fluid stained with Methylene blue and with Gram stain, the physician may be able to plan a more effective therapeutic program. The diagnostic program should include blood culture as well; occasionally this will produce the causative organism when spinal fluid culture fails. Petechiae also should be scraped for smear and culture. The role of the laboratory in diagnosis is a vital one and good bacteriologic technique should be actively encouraged.

Causative Organisms

Our experience regarding causative organisms is seen in Figure 3.

In forty-six cases (30.5 per cent), no organism was found. This group had fourteen deaths, for a mortality rate of thirty per cent.

Hemophilus influenzae was seen in thirty-one cases, or 20.5 per cent of the total number. There were four deaths for a mortality rate of 13 per cent. The ages ranged from two months to six years, with all but five in the first two years.

Neisseria meningitis was seen in twenty-eight, or 18.5 per cent of the cases, with three deaths, for an eleven per cent mortality rate. Ages ranged from two months to thirteen years, with all but eight between five months and three years.

Organisms identified only as Gram negative rods were seen from fourteen patients, or 9 per cent. Four of these died, for a mortality rate of 29 per cent. Three of this group were less than one month old, the rest were scattered throughout infancy and childhood.

Gram negative diplococci were seen in thirteen instances, or 8.5 per cent. There was one death, for a rate of 7.7 per cent. These cases were scattered throughout infancy and childhood.

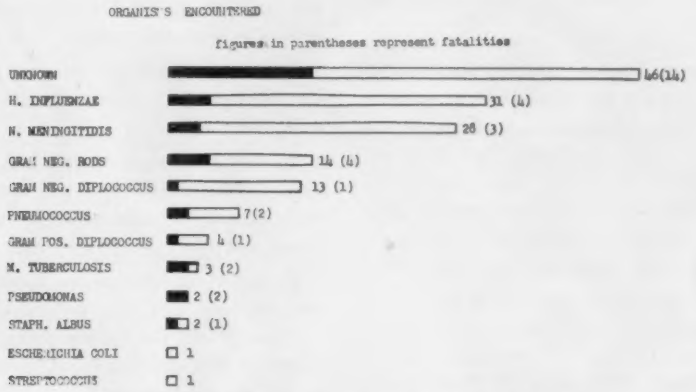

Fig. 3. Organisms encountered. Figures in parentheses represent fatalities.

TABLE III. MENINGITIS MANIFESTATIONS
(From *Pediatrics*, Vol. 17, February 1956.)

IN THE NEWBORN	
CYANOSIS	
FEVER	
VOMITING	
JAUNDICE	
JITTERYNESS OR DROWSINESS	
IN OLDER INFANTS	
FEVER	
VOMITING	
JITTERYNESS OR DROWSINESS	
CONVULSIONS	
BULGING FONTANELLE	

TABLE IV. NEWBORN SEPTICEMIA
(From *Pediatrics*, Vol. 17, April 1956.)

EARLY CLINICAL FINDINGS	
FEVER OVER 101	47%
GASTROINTESTINAL	30%
JAUNDICE	29%
SKIN LESIONS	24%
CENTRAL NERVOUS SYSTEM	15%
OMPHALITIS	9%
LATER CLINICAL FINDINGS	
FEVER OVER 101	51%
HEPATOMEGALLY	33%
ICTERUS	32%
MENINGITIS	26%
SKIN LESIONS	21%
CENTRAL NERVOUS SYSTEM	13%

Pneumococcus was identified seven times, or 4.6 per cent. The mortality numbered two, or a rate of 28 per cent. The ages ranged from one month to six years, but all except one were in the first thirteen months.

Gram positive diplococci were seen four times, or in 2.6 per cent. There was one death.

Tuberculous meningitis was proven in three patients, with one survival. A tremendous decrease in incidence compared to earlier studies that found tuberculous meningitis to be one of the most common types.[3]

Pseudomonas was found twice, fatal on both occasions. The ages were newborn and seven years.

Staphlococcus albus was present twice, fatal once.

Escherichia coli and streptococcus were each identified once. Both patients recovered.

Effect of Treatment Prior to Diagnosis

It is well known that previous antibiotic therapy often makes identification of the causative organism difficult or impossible. When this occurs, precise antimicrobial planning is usually impossible.

Our experience in this regard revealed that, of the fifty-two patients known to have had antimicrobial therapy prior to diagnosis, organisms were observed in twenty-three cases. In the ninety-nine patients not known to have had antimicrobial therapy before diagnosis, eighty-two had organisms observed. For the two groups the fatality rate did not differ significantly. Of the fifty-two receiving prior treatment, ten died. Of the ninety-nine not known to have had prior treatment, twenty-four died. This last group includes most of those having a rapid fulminating course who died a few hours after being first seen and admitted to the hospital.

Of the sixteen patients known to have residual central nervous system damage, seven were known to have had antibiotics prior to diagnosis. Seventeen of the twenty-nine patients with a hospital stay of over three weeks had also received antibiotics before spinal fluid examination.

Therapy

Once the diagnosis of meningitis is established, treatment should not be delayed. Effective blood and tissue levels of antimicrobial agents are most rapidly obtained by intravenous administration. Frequently, it is possible to do this at the same time veneclysis is performed for the blood culture.

With the large number of physicians composing the attending staff, one would expect to see a large number of therapeutic programs. However, in recent years the tendency has been for the management to become quite similar, with most patients being placed on programs closely resembling those advocated in recent articles on the subject.[1,2,5]

When the organism is unknown, most patients receive sodium sulfadiazine, chloromycetin, and crystalline penicillin all in large dosage. Some authorities [2,5] feel that all patients should be started on multiple antibiotics in this manner, dropping the less effective agents when the culture and sensitivity studies become available. However, others[1] feel that more accurate treatment is often possible.

In *H. influenza* infections, chloromycetin is usually the most effective antibiotic. Dosage ranges from 75 to 100 mg/k. Other broad spectrum agents and sulfadiazine are useful with this organism. *H. influenza* type B antiserum was felt to have speeded improvement noticeably in several of our own cases.

For meningococcus infections, sulfadiazine is the therapy of choice. Penicillin is often used with the sulfa.

In pneumococcus meningitis, it is generally agreed that penicillin is the most effective agent and should be administered in frequent large doses, 1,000,000 units every four hours.

Pseudomonas aeruginosa meningitis has a better prognosis now that polymixin B is available.

Tuberculous meningitis therapy is outside the scope of this discussion. The reader is referred to an excellent report.[6]

Complications

Of the early complications of meningitis, peripheral vascular collapse is the most dangerous. It must be watched for carefully and treated vigorously. The picture of acute adrenal insufficiency encountered in the Waterhouse-Friderichsen syndrome is well known and in this emergency hydrocortisone is useful. Whole blood, intravenous fluids, and levarterenol may be required as well in order to bring the patient out of the peripheral collapse.

In addition to the shock produced by acute adrenal insufficiency, it is recognized that septicemia can cause peripheral vascular collapse.[7,8] Shock of this etiology is treated much like that of adrenal collapse with more emphasis on the use of levarterenol.

Of the thirty-four deaths in our series, postmortem examinations were performed on twenty. Of these, only two had hemorrhagic destruction of the adrenals. One of the two produced a growth of meningococcus and the other had a rash typical of meningococcemia. Meningococcus was cultured from two additional cases, and one other with a hemorrhagic rash. However, these had no anatomic adrenal abnormality. A suprisingly frequent postmortem finding was degenerative changes of the renal tubular epithelium. This was seen in fourteen of the twenty postmortem examinations. Experimental work on the effects

of hypotension on the kidneys of dogs[9] may explain this finding.

Subdural fluid formation is another complication deserving mention. This well-described entity[10] is responsible for many of the postmeningitis central nervous system defects, but is easily diagnosed and not too difficult to treat, with gratifyfying results when recognized early and treated properly. Diagnosis is made by subdural tap. Indications for subdural tap are: Failure of temperature curve to show a progressive decline, positive spinal fluid culture after forty-eight hours of adequate therapy, convulsions during the convalescent period, gross neurologic abnormality, clinical impression that the course was unsatisfactory, and enlargement of the head circumference.

Summary

The pediatric meningitis cases of Hurley Hospital were reviewed, and the survival rate was found to be improving.

Clinical and laboratory findings were tabulated and discussed.

The difficulty in recognition and changing physical manifestations at early age groups are discussed, and the importance of early diagnosis and early intelligent therapy is stressed.

Peripheral vascular collapse and subdural fluid complicating meningitis are discussed briefly.

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"THE MEDICAL WITNESS"

The American doctor, increasingly on call as a courtroom witness, is about to receive expert help in presenting his testimony.

The American Medical Association and the American Bar Association have joined forces for the first time to present a series of educational films dealing with the professional relationships of doctors and lawyers, according to announcement by Dr. George F. Lull, secretary and general manager of the AMA.

The first film in the series, "The Medical Witness," had its premiere showing at the AMA's clinical meeting in Seattle, Washington, November 27. The film is now available for showings before medical societies, bar associations, and other professional groups throughout the country.

"The Medical Witness," a thirty-minute black and white 16 mm. film, depicts right and wrong methods of presenting medical testimony by re-enacting the trial of a personal injury case. The series is being produced by The William S. Merrell Company of Cincinnati, ethical pharmaceutical manufacturer, as a service to the medical and legal professions.

Stressing the "vital importance of these films to all doctors and lawyers," C. Joseph Stetler, head of the AMA's law department, said:

"Medical testimony is required today in from 60 to 85 per cent of all cases litigated.

"The taking of medical testimony is at the core of court operations in personal injury cases. Medical societies and bar associations are increasingly concerned about the problems which arise in the practice of presenting medical evidence through partisan experts hired by parties to law suits.

" 'The Medical Witness,' the lead-off film in this series, shows doctors and lawyers how to develop expert testimony that is truly objective and scientific and in the best interests of the plaintiff, the judge and the jury.

"Our central purpose in all these films is to acquaint doctors and lawyers with each other's professional, procedural and ethical problems in litigation and other areas where two professions come into contact."

"The Medical Witness," Mr. Stetler said, deals specifically with questions that concern both professions, such as the following:

1. What is and should be the relationship between the medical witness and the lawyer?
2. What is the most effective way to examine and cross-examine the medical witness?
3. How does the medical witness support his opinion?
4. How does a jury react to the testimony?

Medical societies wishing to arrange for showings of "The Medical Witness" and later films in the series, may write to the Film Library, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois. Bar associations should write to the National Legal Audio-Visual Center, Indiana University, Bloomington, Indiana.

A Plea for Preschool Eye Care

By R. T. Blackhurst, M.D.
Midland, Michigan

THOSE of you who have two good eyes may regard this brief article with little interest, and many of you will retain none of its content. Those of you who have but one good eye may momentarily reflect back on your childhood and wonder what, through the span of years, that tremendous handicap has meant to you. Such reflection may bring forth a question. What are we as physicians doing for today's children with similar visual defects? The answer may bring surprise and disillusion! There are more one-eyed children of school age being seen by ophthalmologists today than ever before.

The school health program is a huge success and a growing tribute to the general practitioner and pediatrician. In contrast, the school vision screening program is sending us an alarming number of partially blind "healthy" young Americans. In most cases this partial blindness could have been prevented.

It would seem that the problem is one of ignorance—ignorance of the growth and development of vision. If we as physicians have been negligent or lethargic, certainly parents must be excused. All of us have been taught the fundamentals of child development. Even the most conscientious parent, however, can be expected to have only the most meager knowledge of vision. Most of them honestly feel secure in waiting until the child reaches first grade before having that initial eye examination. Currently many parents even wait for the results of the first school screening of the child's eyes. For many years parents have understood that dental health is best assured if the teeth are checked by age three, and yet there is almost universal ignorance as regards the more important topic of how eyesight develops.

The problem is twofold. It involves the early detection (and treatment) of: first, eyes which are poorly aligned, and, second, eyes which have an optical defect (hyperopia, myopia or astigmatism), particularly when only one of the eyes is involved. When left undiscovered and untreated, the end result in either case is often the same—permanent loss of all useful central vision in one eye (amblyopia).

Each of us has two separate and distinct types of vision—one peripheral and one central. Peripheral vision is present at birth or develops shortly thereafter. It is this function which permits an infant to follow lights and moving objects and which later permits him to walk without bumping into things. The peripheral fields of the two eyes partly overlap and are therefore part of the binocular pattern, although they alone cannot maintain useful binocular vision.

Central vision on the other hand develops slowly and gradually throughout the first six years of life. A small infant has no ability to fixate—no critical or sharp vision. This process so important for reading, driving, watching "TV," et cetera, consists of only a few degrees in the central portion of the visual field. It is the essential backbone of binocular vision and stereopsis. Without it there can be no guarantee of parallel or straight eyes. The visual mechanism cannot be expected to maintain permanent alignment in the absence of two sharp, identical pictures which may be fused into a single perception. Young eyes develop by doing. Only by constant repetition of the process of observing, studying and concentrating on small objects, shapes and outlines does central vision develop in the eyes.

Amblyopia affects only central vision. It is actually "an island of blindness in a sea of vision." This is true because the brain must ignore only that portion of a picture which is sharp enough to be objectionable.

This central "island" can easily be demonstrated. Hold a cigarette between the thumb and forefinger of your left hand extended directly away from the shoulder. Now concentrate on the thumbnail of the right hand held fourteen to sixteen inches in front of your face. If you slowly move the cigarette toward your extended right thumb you will find that it cannot be recognized as a cigarette until it is within fourteen to sixteen inches of the thumb. The presence of a filter

cannot be determined until the cigarette is within five or six inches, and the brand name cannot be read until it is directly in line with the thumb. This small area where the name can actually be read represents central vision, and it alone is involved in amblyopia.

Normally each eye receives a picture—two pictures reach the brain and are blended into one—a single binocular perception resulting in stereopsis. If the eyes are not absolutely straight, two different pictures are presented to the brain and cannot be fused into a single perception. This situation cannot be tolerated, so a reflex pattern is developed whereby the brain ignores one of the pictures it is receiving. The eye whose picture is ignored gradually becomes lazy. It is not continually stimulated and so does not develop. If one of the eyes has a refractive error (hyperopic, myopic or astigmatic), its retina receives and transmits a picture which is blurred or distorted and likewise cannot be fused with the clear picture which the brain receives from the fellow eye. Here again the offending image is ignored, and central vision does not develop.

This deficiency of central vision, or amblyopia, is gradual in onset, and may be easily corrected if discovered early. However, the reflex pattern which has been set up soon becomes fixed. Once a child has reached the age of seven or eight years, it is seldom possible to restore or reclaim the lost central vision.

Often times it is the fortunate child who has an optical defect involving both eyes. He is frequently discovered early in life and corrective glasses restore normal vision and permit further development of that individual's ability to see clearly and binocularly. In such a case the presence of one good eye did not mask the less fortunate fellow.

Whether due to an optically defective eye or a crossed eye, amblyopia can usually be corrected—and nearly always so, if discovered early. Glasses can be prescribed and well tolerated by a child of one year. The defective eye can be made to exercise its capabilities by occlusion of the better eye. Occlusion started within the first two or three years of life is usually rapidly successful if correctly and continuously carried out. The amblyopia is not yet deep seated enough to be irreversible. Corrective glasses, patching (occlusion) of the good eye, and surgery when then necessary to further straighten crossed eyes, may well result in a normal child before school age. When, conversely, treatment is delayed until the age of five, six or seven, the "isle of blindness" is so secure that only prolonged continuous patching can result in any improvement at all—and often this falls far short of normal acuity.

Nowadays, the infant or preschool child with a marked convergent or divergent strabismus is referred immediately to the office of an ophthalmologist where he is treated and often completely corrected before reaching school age. Less fortunate is the child who has a slight strabismus with a barely noticeable deviation. Often he is missed entirely or, when discovered, not referred for treatment because it is too widely felt, even among physicians, that these small deviations will correct themselves.

Although the diagnosis and treatment of such cases has never been cut and dried, hours of thought by many interested people is rapidly resulting in a still changing but gradually crystallizing approach to the problem. The busy practitioner who has been confused by opinions and writings of our own members may now acquire definite answers to most of his questions and be given a simplified program which will satisfy most ophthalmologists and save many eyes.

All of us understand that an infant of less than three months has very little co-ordination and only fair control over his voluntary muscular components. His eyes may not always appear straight! But neither will they always appear crossed! They are normally straight, but may be temporarily in poor alignment while moving to or from the central position. Constant or nearly constant deviation of the visual axes is not normal in a child of any age.

Very often, in conjunction with a "button-nose," an infant will have a wide epicanthal fold of skin which covers a portion of the sclera medial to the cornea and gives the appearance of crossed eyes when the visual axes are indeed parallel. This child may "needlessly" be referred to an ophthalmologist. However, this is a mistake we all make, and I have yet to see a mother angered by the referral. The mistake is usually hers as well as the doctor's. She is relieved and, moreover, thankful that her physician is interested and attentive. It is an "error" in the right direction.

Even this small error may be avoided if the doctor will draw together the skin over the bridge

of the infant's nose, thus uncovering the hidden sclera, and look once more at the eyes. Further security may be gained by a simple and effective "light test." Attract the infant with a small fixation light held three to five feet from its eyes. If the corneal light reflex strikes the middle of both pupils, the visual axes are normally aligned.

The thinking of most practicing ophthalmologists has jelled on the matter of time for referral of these infants. We must "get them early." Crossed eyes do not correct themselves with time. Time extends the physical and emotional defect. The deviating eye becomes lazy; the brain establishes an abnormal pattern of seeing—one difficult to break up: paretic muscles upset the ocular muscle balance so that later diagnosis is more difficult; and most importantly the child is getting older—those few important months during which a child's brain develops the ability to use both eyes together are rapidly slipping away. By the time the child is of school age the battle has either been won or lost. Parents appreciate their doctor's advice and will always continue to thank him for that *"early referral."*

The ophthalmologist has many things to determine and evaluate when he first sees this infant with crossed eyes. Is the defect nonparalytic (the common type), or paralytic? If paralytic, what muscle is involved? At what age was the defect first seen? Was it at first constant or intermittent? Is it always the same eye which deviates? Do other members of the family have a similar defect? Did the infant enjoy a normal, spontaneous, full term birth?

Based on information gathered from you and the parent, and on a careful and surprisingly effective examination of the infant, he may suggest temporary patching of the nondeviating eye, or alternate patching of both. This helps him rule out a possible paresis or anatomic defect of one or more of the ocular muscles. In ocular tortecollis it often helps him determine the affected eye and thus the paretic muscle before the child is old enough to co-operate in an objective study. More commonly, it establishes the fact of equal or unequal vision in the two eyes.

Before a child is one year old he may be carefully examined under cycloplegia, and if a large or contributary refractive error is found in one or both eyes, glasses will be prescribed and, surprisingly enough, proudly and co-operatively worn. Remember that this child is not enjoying normal vision as we know it. When required, glasses are quickly appreciated. If glasses alone do not correct the deviation, supplementary surgery may effectively be performed at this age.

It is apparent from the preceding paragraphs that our only hope in reducing the number of visual cripples in our school system is to begin treatment long before the school bell rings. Accordingly, we appeal to already overburdened general practitioners and pediatricians to add one more item to the examination of the one, two, or three-year-old infant. Make a sincere attempt to evaluate the vision in *each eye*. Help us discover amblyopia while there is still time for successful treatment. Urge a child to fixate a pocket-light, coin or a small toy. Cover one eye then the other; ask yourself if he fixates and follows with equal ease using either eye. Try him on a picture chart while the eyes are alternately patched. Throw a few cotton balls on the carpet before an infant and see if he retrieves them with equal ease using right and then left eye. If you question the equality of vision; by all means repeat the tests at a later date.

If further information is desired, dilate the pupils with 5 per cent homatropine or 1 per cent cyclogyl* and study each retina carefully. They should be seen with equal ease and clarity. Refer all doubtful cases to a capable eye physician. The child and its parents will be grateful.

Practice these tests on your own child—you may be surprised! Trouble is often found where least expected!

*Cyclogyl 1 per cent, brand of cyclopentolate hydrochloride, Schieffelin & Company, New York 3, New York.

BRAIN TUMORS

In fifty brain tumors confined to the occipital lobe, the *symptoms* in order of frequency were: headache, nausea and vomiting, defect of visual field, failing visual acuity, ataxia, hallucinations and diplopia.

The *signs* of brain tumor in this same series in order of frequency were: defect of field, papilloedema, cerebellar signs, weakness of face or extremities, aphasia, alexia, visual agnosia and agraphia, sixth nerve palsy, inactive pupils and paresis of accommodation.

Rheumatic Fever Prophylaxis

By Robert E. Fisher, M.D.
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A NOTE in *Circulation,* XIV, 1020 (November, 1956) states that there were thirteen recurrences of rheumatic fever in a group of 400 children who had been on prophylaxis two years. Four were on sulfadiazine, nine on oral penicillin and none on benzathine penicillin G intramuscularly.

Effective Jauary 1, 1957, the prophylaxis program of the Michigan Department of Health and the Michigan Crippled Children Commission has been expanded to include the use of sulfadiazine when the doctor feels that benzathine penicillin G is harmful to the child. He may secure sulfadiazine by so noting on the "Requistion for Benzathine Penicillin G," Health Department Form C-62A, in quantity of three bottles of 100 tablets of 0.5 gm., a five-month's supply for anyone weighing over sixty pounds. This is obtainable for anyone who has rheumatic heart disease or who has had rheumatic fever upon reporting the case on the requisition form, at no cost to the doctor or his patient.

Fees for regular follow-up office visits and necessary laboratory work may be paid from trust funds administered by the Michigan Crippled Children Commission when the child is not yet twenty-one and has been the subject of a court order under the Crippled or Afflicted Children's Acts. An amount equivalent to that which benzathine penicillin G administration would entail has been made available for these services. The laboratory work may be done by the doctor or by the hospital to which he sends his cases; in the latter case, the laboratory must be one at a hospital approved for care of afflicted children. The published Michigan Crippled Children Commission fee schedule applies.

An initial visit, with progress visits one, three, five and then every two and one-half months thereafter, with a urinalysis, hemoglobin, white blood count, differential on the initial and next two visits and at seven and one-half months and every five months thereafter, can be alternated with visits without laboratory work at five months and every five months thereafter to check on the use of medication, or the child can be seen less frequently or more frequently, within the monetary allowance, as the doctor desires.

A report is required on each visit. When four visits have been made, the report is submitted with an invoice-voucher for payment for the service rendered.

Members of the Michigan State Medical Society provide, through the Rheumatic Fever Diagnostic Centers, consultation service for doctors seeking clarification of the diagnosis and recomendations for therapy. Where the cost of the consultation prevents use of the service, in the case of a minor, the doctor may execute Michigan Crippled Children Commission Form 121 (Physician's Certificate) requesting such a consultation. The cost of transportation to the Center cannot be paid by the Commission, but the Center's fee for service is paid under the order pursuant to the certificate. Should the recommendation be that prophylaxis is indicated, this patient who has had a court order, albeit limited, is eligible for inclusion under the prophylaxis program. It must be understood that a court order is not a prerequisite to the obtaining of benzathine penicillin G or sulfadiazine from the Michigan Department of Health, and the doctor may charge a fee for its administration and supervision with propriety.

As of January 1, 1957, the Michigan Crippled Children Commission has received billings for administration of 552 doses of benzathine penicillin G to 140 children. In four cases injections were discontinued. There were no rheumatic fever recurrences reported, but one patient developed subacute bacterial endocarditis while on benzathine penicillin G, was treated with penicillin, and is back on benzathine penicillin G prophylaxis.

"A Diagnosis of Rheumatic Fever is a Mandate for Prophylaxis"

Dr. Fisher is Medical Co-ordinator, Rheumatic Fever Program, Michigan Crippled Children Commission.

Rubella in Pregnancy

By Warren H. Pearse, M.D.
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RUBELLA occurring in the pregnant woman has recently been presenting an increasing problem to obstetricians. What incidence of fetal anomalies is to be expected? Is therapeutic abortion justified when rubella occurs? What can we tell our patients who develop rubella in early pregnancy—in late pregnancy? There appears to be considerable confusion as to the correct answers to these questions, and we therefore undertook a review of available information to clarify, insofar as possible, our own thinking regarding these questions.

Rubella, or "German Measles," is a self-limited communicable viral disease, characterized by mild constitutional symptoms, a transient maculopapular rash, and swollen, tender postauricular and postoccipital lymph nodes. It often occurs in epidemics with rubeola, especially in the spring, and one attack confers a permanent immunity. It can be distinguished without particular difficulty from such conditions as scarlet fever, rubeola and exanthem subitum. However, because of the mild nature of the disease a physician is not always consulted.

Rubella had always been considered a benign infectious disease of childhood until the epic work of Gregg[1] disclosed the high incidence of congenital cataracts in the eyes of infants delivered of mothers who had contracted rubella during the Australian epidemic of 1941. This was later amplified by Swan, et al,[2] and gradually a series of defects including deafness, congenital cataract, congenital heart disease (largely patent ductus arteriosus), central nervous system damage and dental malformations were related to the disease. Our concern here is with rubella only, and although isolated case reports of a variety of deformities in mumps, measles, chickenpox, herpes zoster, infectious hepatitis, infectious mononucleosis and poliomyelitis have been made, there is at present insufficient evidence to incriminate these in any way comparable to rubella.[3] It is also to be emphasized that the usual mild course of rubella is seldom altered by pregnancy, and the concern is not for the mother, but specifically regarding possible damage to the fetus.

What then are the possibilities of fetal damage if the pregnant woman develops rubella? The data from the Australian epidemic of 1941 have been summarized by Collins.[4] In 383 cases of maternal rubella during various months of pregnancy the incidence of fetal anomaly was as follows:

Month	Per Cent
1	79%
2	90
3	80
4	78
5	24
6	21
7	27
8	25
9	0

However, the dangers of a retrospective study (i.e., finding anomalies and then looking back to see how many mothers have had rubella) have been pointed out by most authors, and this study was of that nature. In the same summary Collins stated that a study in Queensland of every pregnant woman who had contracted rubella during the first trimester of her pregnancy in the year 1941 revealed only a 30 per cent incidence of affected infants.

An ideal study—one in which pregnant women who develop rubella are observed to term and the infants studied together with adequate controls—is difficult of realization. However, such an investigation has been approached by Lundstrom[5] who analyzed an epidemic of rubella in Sweden in 1951. All patients who delivered or aborted in a maternity hospital (as do 94.1 per cent of Swedish mothers) were questioned in detail about exposure to or development of rubella. Lundstrom's findings are summarized below. *Anomaly* encompasses any defect present at birth, including such things, besides the "rubella syndrome," as hypospadias, multiple nevi, hydrops fetalis and even asphyxia neonatorum. The group of *stillbirths and neonatal deaths* includes the occurrence of these from all

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TABLE I. LUNDSTROM'S SUMMARY OF RUBELLA EPIDEMIC IN SWEDEN IN 1951.

Group	Contracted Rubella		Contact—No Infection				Controls
			Non-Immune		Immune		
	1-16 weeks	16-40 weeks	1-16	16-40	1-16	16-40	
Anomaly	4.5%	3.4%	1.8%	1.3%	5.4%	0.7%	1.4%
Stillbirth & Neonatal Death	5.9%	2.1%	3.5%	3.1%	4.4%	1.6%	3.2%
Cases	579	450	344	508	153	240	2226

causes except complications of late pregnancy and delivery. This group also includes malformed dead infants. Durations of pregnancy are calculated from the first day of the last menstrual period.

Some criticisms can be made. The diagnosis of rubella in these cases was not always medically confirmed. 275 cases who were "legally aborted" were excluded, as were 107 who received convalescent serum. Some defects actually present, such as deafness, might not have been recognized at birth. Perhaps the latter would be compensated for by the author's inclusion of minor anomalies unrelated to the infection. In any event, this large well-controlled study certainly indicates a much lower fetal risk than previously believed.

Figures from the United States are not so readily available. Ingalls and Purshottam[6] summarized in 1953 the results of previous small studies together with their own.

—AD—table II

Greenberg[7] (quoted by Krugman and Ward) reported a series of eighty-two patients who contracted rubella in the first trimester. There were nine stillbirths (11 per cent) and five anomalies (6 per cent). A recent report of Brawner[8] concerns twenty-six cases seen in a mild outbreak in Georgia in 1952. These are listed as available cases; whether others may have occurred is unknown. Fifteen cases in the first trimester produced four anomalous infants and one stillbirth (33 per cent). Seven cases in the remainder of pregnancy gave rise to only two minor muscular abnormalities, probably unrelated to rubella. Four patients had therapeutic abortions performed.

As information accumulates, it would seem there is little risk when the mother develops rubella beyond the sixteenth week of gestation. Prior to that time, we can estimate an incidence of about 5 to 7 per cent fetal anomalies and 6 to 10 per cent stillbirths on the basis of the larger studies presently available.

TABLE II. INGALLS AND PURSHOTTAM'S SUMMARY OF RUBELLA AMONG PREGNANT WOMEN IN THE UNITED STATES.

	Cases	Anomalies	Stillbirths
1st Trimester	42	3	4
2nd Trimester	23	2	2
3rd Trimester	7	0	0
	72	5 (7%)	6 (8%)

What should be the program when rubella exposure occurs during the first sixteen weeks? At present, pooled gamma globulin or convalescent serum is being administered, but its effectiveness is open to question. Krugman and Ward[7] conclude from four separate studies that neither convalescent serum nor ordinary gamma globulin has been consistently effective in prevention of rubella. With the use of these preparations there is an additional problem. The course of rubella may be modified so that it occurs in a subclinical form, but anomalies apparently do develop from this type of infection while the patient and her physician may be falsely reassured that the disease did not occur.

If rubella develops in these first sixteen weeks, should therapeutic abortion be performed? This may, of course, be impossible because of moral or religious beliefs. It is also interesting to note that under the laws of the state of Michigan pregnancy can be interrupted only to preserve the life of the mother. Interruption for fetal indications would be well outside this boundary. This latter dilemma is not peculiar to Michigan, however, as a recent summary of therapeutic abortions in New York[9] states that even many abortions agreed to by a hospital staff committee may be in a quasi-legal group.

Outside the above considerations, certainly the age, parity and ease of conception of the patient must be taken into account. With these facts at hand, each physician must decide whether a 5 to 7 per cent increased incidence of fetal anomaly or the risk of stillbirth should prompt consideration of interruption of pregnancy in a mother less than sixteen weeks pregnant.

Summary

1. The rubella problem in pregnancy has been reviewed.

2. Large series of recent years show an incidence of fetal anomalies of 5 to 7 per cent and

(Continued on Page 363)

The Physician and the Adoption of Children

By Ernest H. Watson, M.D.
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THE ADOPTION of children is "big business." Each year there are approximately 150,000 illegitimate births and 25,000 to 30,000 young children who lose their parents through death, separation or desertion. Each year there are approximately 90,000 adoptive placements, about half of which are not made by official agencies.*

Physicians, particularly general practitioners, obstetricians and pediatricians, are frequently asked by persons and agencies involved in adoption to give opinions and lend aid in one way or another. What may the physician ethically and properly do to aid children find a home, and childless couples to obtain a child? What should the physician refuse to do in this connection?

I should like to emphasize one point at the beginning because it should have priority over all others: The first consideration in all adoptive placements should be the finding of a good home for the child. Next, we can place the problem of finding a child for a family, and of lesser importance must be the solution of the social problems of illegitimate pregnancy, payment of hospital bills, relief of a county or community of the burden of caring for a homeless child.

The first and most natural mistake for a physician to make is to agree to help some childless couple find a child for adoption. The physician is likely to place himself immediately in the partisan position of being an agent, in a sense, of the childless couple. If they are friends or patients of his it may be difficult for the physician to do what he should do, and in some states the only thing he can legally do, i.e., to refer the couple to an official child placement agency. He is likely to feel like he is "passing the buck" or letting his friends down. Such is not the case. It may be a real disservice in the long run to put the childless couple in touch with some illegitimately pregnant woman who is looking for financial aid and seeking disposition of her unborn, unwanted baby. As immediately helpful as this arrangement might be to the child's natural mother, it violates one cardinal principle of successful adoptive practice, namely, complete anonymity between natural and adoptive parents. Blood relationship of parties involved sometimes makes it necessary to ignore this principle of anonymity, but even then the future relationships are in some jeopardy.

The physician may believe that his knowledge of a childless couple is as good or better than any possible social history obtained by an agency worker and it may be so, but another principle of proper adoptive practice involves an investigation of the family by a completely nonpartisan agent. This investigation must be thorough enough to establish the quality and integrity of the family and their motive for wanting to adopt a child. This latter seems obvious at first glance, but is not so simple. Some couples want children to be in style in their social set; some want to pull together a marriage threatening to fall apart; some wish to replace a lost child; others because they love children and feel an aching void because of their childlessness.

The Child Welfare League of America has suggested the following set of minimum safeguards in adoption:

I. The safeguards that the child should be given are:
   1. That he be not unnecessarily deprived of his kinship ties.
   2. That the family asking for him have a good home and good family life to offer, and that the prospective parents be well-adjusted to each other.
   3. That he is wanted for the purpose of completing an otherwise incomplete family group in which he will be given support, education, loving care, and the feeling of security to which any child is entitled.

II. The safeguards that the adopting family should expect are:
   1. That the identity of the adopting parents should be kept from the natural parents.
   2. That the child have the intelligence and the physical and mental background to meet the

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*An official agency in Michigan is one licensed by the State Department of Social Welfare to place children for adoption. The only public agency authorized to place children for adoption in Michigan is the Michigan Children's Institute in Ann Arbor.

reasonable expectations of the adoptive parents.

3. That the adoption proceedings be completed without unnecessary publicity.

III. The safeguards that the state should require for its own and the child's protection are:

1. That the adopting parents should realize that, in taking the child for adoption, they assume as serious and permanent an obligation as do parents rearing their own children, including the right to inherit.
2. That there be a trial period of residence of reasonable length for the best interests of the family and the child, whether there be a legal requirement for it or not.
3. That the adoption procedure be flexible enough to avoid encouragement of illegitimacy on the one hand, and trafficking in babies on the other.
4. That the birth records of an adopted child be so revised as to shield him from unnecessary embarrassment in case of illegitimacy.

The physician should be aware of the requirements of Michigan Law on adoption. The law (comp. Laws Michigan (1948) Section 710.1—710.14) states that the judge of probate is required to have a full investigation "by the county agent, probation officer, or by a placement agency licensed by the state, or by the Michigan Children's Institute or the State Department of Social Welfare." The purpose of the investigation is to determine several things: The integrity, health, and stability of the home into which it is proposed to adopt the child, the physical and mental health of the child, the child's family background and suitability of the child and adoptive parents on racial, religious and cultural backgrounds.

Legal Provisions Which the Physician Should Know

1. Adoptions are under jurisdiction of the probate court of the county in which the petitioners reside.

2. Consent of both parents must be obtained, except in cases of illegitimacy where the natural mother's consent alone is enough.

3. Release of the child by its parents (or by its natural mother in case of illegitimacy) to the probate court prior to any steps toward adoption is highly desirable, since it makes much easier the preservation of complete anonymity between natural and adoptive parents.

4. The probate court must order an investigation of the principals and circumstances in every case of adoption.

5. The only entirely legal way in which the physician can act as the go-between or "arranger" in the matter of adoption is either to have himself appointed guardian of the child while arrangements are being made, or, second, to obtain a license from the Department of Social Welfare to serve as an authorized child-placing agency. Both of these activities seem out of character and at the least an unusual role for the busy physician. He could find himself with guardianship or other responsibilities far more demanding than he had bargained for.

6. A physician (or hospital) may not give "free" services to an illegitimately pregnant woman on the condition that she release her baby for adoption to a certain couple.

7. A physician cannot legally prevent a mother from seeing her child (as in case of a new born illegitimate infant in the hospital) simply because she has previously indicated an intention or even an agreement to place the child for adoption. Only the probate court can sever parental rights.

8. Hospitals, clinics and maternity homes giving maternity service are required by Michigan law to file a special report on illegitimate births. The physician is liable to fine and worse if he conspires to hide the fact of illegitimacy by having the mother register at the hospital under an assumed name and status. One common violation of the law is to have the mother register in the name of the wife of the couple planning to adopt the baby. This, if it works, does get the baby a birth certificate carrying the family name he will presumably have, but it is an illegal stratogem full of chance of trouble for all concerned. There is no need to go to such lengths as far as the birth certificate is concerned. In cases of proper adoption the judge of probate can issue a new birth certificate carrying the adopted family name and covering the fact of illegitimacy.

From the foregoing it can be seen that the judge of probate will order a complete investigation and that the physician cannot and should not attempt to "short-cut" these necessary legal procedures which are based on sound considerations. If there is still doubt in the physician's mind as to the qualifications and desirability of an official adoption agency taking charge, consider the following contributions of the professional agency staff as set forth in the Child Welfare League of America's publication "A Study of Adoption Practice":

1. Only an agency offers the child and adoptive parents a wide choice as a safeguard to suitable placement. The agency may have a hundred couples from which to choose just the right home for a child.
2. An agency offers experienced staff to assemble and evaluate professional data of various kinds—medical, legal, psychological, et cetera—in the light of the specific child-parent situation. (The physician is not a social worker.)
3. Only an agency prepares, preserves, and makes available the record of the whole transaction.
4. There is the major advantage that the agency acts as the confidential intermediary between the natural parents and adoptive parents.
5. The agency brings a large body of experience into this field, which cannot be matched by those doing private adoptions.
6. The agency can assure care for the child if he becomes unadoptable—a protection for the natural parents and adoptive parents, as well as the child.
7. Casework with the natural parents, which can be given only by an agency, gives assurance that the surrender is final.
8. Assurance that the adoption will be consummated legally, or else that some other appropriate form of care will be provided for the child.

The physician can give advice to agencies and persons involved in adoption practices only when he knows certain facts relating to the principals involved. He is most often called on to "give an O.K." on the physical and mental status of a child to be placed. Obviously, the younger the child the more difficult it is to appraise mental development, even when a psychologist's help is available. In most instances, the physician is not given a good enough medical history of the infant's ancestors to enable him to give a good opinion on the possible inheritance of undesirable traits by the infant. Thus, it is obviously important that all persons in a position to know facts of medical importance in this connection make them a part of the child's hospital and agency record. Everyone gives lip service to the ideal of early adoption (early infancy); this may definitely be brought about if a good family and medical history of both natural parents is available. If babies are adopted as early as a few weeks of age, it seems highly advisable from the medical standpoint to insist that the usual one-year probationary period not be waived (it can be waived by the judge of probate) and that the infant be re-examined repeatedly during this year. It should be kept in mind, of course, that most couples who adopt babies run little if any more risk that the child will not "turn out well" than if they had been the natural parents themselves. Proponents of the environmental school will agree with this. Those who believe that the genes largely determine the traits, abilities, et cetera, of the adult will not agree so wholeheartedly. Even so, most ventures of life, such as marriage and parenthood, are fraught with some chance taking. Each adoption, just as each birth of a child into a family has the element of chance in the eventual outcome.

Summary

The role of the physician in adoptions should be a medical one only. He is not a social worker, nor should he try to substitute for the legally constituted authorities in this very important function. The physician is essential for only he can give advice on matters of health, growth and development, and genetic influences relating to the infant, and the natural mother's prenatal care. The details of the birth, and medical and developmental records on the infant are all extremely important factors in final decisions as to placement. Few, if any, human beings are perfect specimens. This applies to babies up for adoption. Only a physician can advise on the probable long term influence of such adnormal findings as the child may have. Physicians should know the agencies in the community to which he can refer childless couples seeking infants or natural parents who think they cannot take care of children (born or unborn). The physician is usually in a position to help the agency and to increase its effectiveness and prestige by his support. Finding the right home for a child is sufficiently important for all persons involved therein to work together.

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Hyperextension of the Fetal Head in Breech Presentation

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THERE are several factors concerning the diagnosis and management of breech presentation which are well known from repeated experience. The purpose of this paper is to review available literature on one complication of breech presentation, namely the hyperextension of the fetal head, and to present an additional case.

Though the incidence of breech presentation is approximately 4 per cent of all deliveries in numerous reported series of breech studies, there are to date only twenty cases of hyperextension of the fetal head reported in the literature. The first work was done by Brakemann,[1] who estimated that in 11 per cent of breech presentation the head was extended in some degree. He postulated that this increased the duration of labor and contributed to a difficult delivery. This work was supported by Stein[2] in his study of deflexion of fetal parts in breech presentations. He warned that the fetal attitude and presentation must not be assumed to be static. This concept must be realized for the intelligent management of the individual case. It may also explain the spontaneous correction of these abnormal presentations. The advisability of attempting external version is questioned because of the basic etiologic conditions making the breech presentation necessary. Stein does not consider deflexion attitudes to be an indication for Cesarean section. He feels that fundal pressure during delivery may be used to deflex the extended parts. Vaginal delivery was accomplished in the two cases reported, one using manual flexion of the head through the vagina before engagement of the head. The second case was one with an arcuate urterus. In 1948, Taylor[3] reported one case of hyperextension of the head in a breech presentation which was delivered by Cesarean section. Roentgen rays of the infant on the sixth neonatal day demonstrated an anterior dislocation of C1 on C2 and of C3 on C4. These were treated successfully with splints. In the same year, Melody[4] reported a case with spontaneous correction of a hyperextended head. The infant had bilateral posterior dislocations of the tibia, suggesting the association of dislocations with hyperextension and flexibility of the spine.

Wilcox[5] reported eleven cases of hyperextension of the head in a series of 1918 breech deliveries. The majority were treated conservatively. Cesarean section was done in four of these cases: two for contracted pelvis, and one each for placenta praevia and prolonged labor. The fetal morbidity was high. Following vaginal delivery, one infant was stillborn and one had a transection of the spinal cord. One baby delivered by Cesarean section, had a cyst on the neck which may have contributed to the extension of the head. Wilcox disagrees with Brakemann in the management of these cases. He recommends individualization of the case and does advocate delivery by Cesarean section. Reis and DeCosta[6] report two cases of hyperextension of the fetal head in breech presentation with spontaneous resolution. They state that this complication is not an indication for Cesarean section. Dougherty[7] reports one case, delivered by Cesarean section, in which the infant's head remained in extension for several days after delivery. Eurard and Allrich[8] report two cases, one of which was delivered by Cesarean section from an arcuate uterus. The second patient was delivered per vaginum. The infant died in twelve hours, and autopsy demonstrated a transection of the spinal cord in the cervical area.

Case Presentation

The case presentation is that of a twenty-five-year-old white female, gravida 2, para 1, admitted to the Grace Hospital on December 17, 1955, not in labor. The last menstrual period was February, 1955. The expected date of confinement was December 3, 1955. The past medical history was noncontributory. The obstetric history consisted of one living male child, weighing six pounds and twelve ounces, born by normal spontaneous vaginal delivery following a twelve hour labor, in 1954. The present pregnancy was uncomplicated. The blood pressure remained normotensive throughout. The weight gain was thirty-one pounds. One week prior to admis-

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sion a plus one edema of the ankles was noted. There was a slight trace of albumin in the urine. The hemoglobin was 13 grams. The red blood count was 4.14 million. X-ray of the pelvis demonstrated, in the right

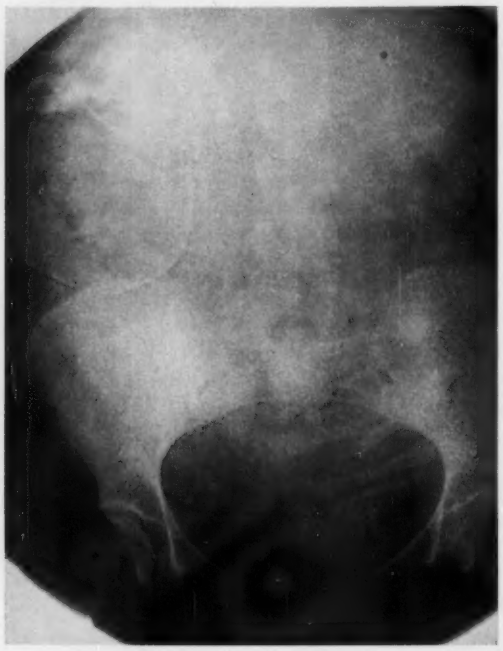

Fig. 1. A flat plate of the abdomen demonstrating a breech presentation with extreme hyperextension of the fetal head onto the fetal spine. Hospital No. 216488.

anterior portion of the uterus, a double footling breech presentation with the head in hyperextension. The pelvic measurements were adequate except for a true conjugate of 10 cm. The patient went into spontaneous labor at 5:40 a.m. on December 18, 1955. Anticipating difficulty in delivery of the hyperextended fetal head, a low cervical Cesarean section was done under local and intravenous penthotal anesthesia. The living seven pound, two ounce, female infant was of normal development. The head tended to remain in hyperextension for six weeks following delivery. No maternal factors were noted to explain the breech presentation.

Discussion

Hyperextension of the fetal head in breech presentation is not common. It is defined as hyperextension of the fetal head with flexion of the fetal spine, and with no relation to the position of fetal extremities. It must be differentiated from opisthotonus fetalis, which was defined in 1915 as a condition in which the fetal spine is hyperextended throughout its length. It usually occurs in transverse presentations. The etiology of hyperextension of the fetal head in breech presentation is not known. Reis and DeCosta favor chance occurrence. Wilcox postulates fetal abnormalities, such as cysts of the neck, spasm of the fetal muscles, and uterine anomalies as the arcuate uterus of Stein and of Eurard, or space-occupying uterine tumors. Certain hypermobility of the fetal joints must be considered as evidenced by the frequent association of dislocations of the spine and other fetal joints with cases of hyperextension of the fetal head. The definite diagnosis is made by x-ray.

The presence of this condition does not influence the course of the pregnancy. It does not increase maternal morbidity except for that normally associated with Cesarean sections. Fetal morbidity is increased due to the basic cause of the breech and to the hyperextension of the head. Transection of the spinal cord with dislocations of the cervical vertebrae are the real dangers.

There is disagreement as to the management of these cases. Stein and Reis and DeCosta advocate vaginal delivery. Wilcox and Dougherty state that this is an indication for Cesarean section, but that the treatment in each case should be individualized.

Summary

A review of the literature and a case presentation of hyperextension of the fetal head in breech presentation is given. The etiology of this condition is unknown. The maternal morbidity is not increased, but the fetal mortality and morbidity is increased. The management is to effect delivery through the vagina or by Cesarean section when indicated.

Acknowledgment

Grateful acknowledgment is given to Dr. K. Miller, for permission to present this case.

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Management of Breech Presentation and Delivery

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BREECH presentation is always a timely topic for discussion because breech delivery still carries even a corrected fetal mortality of about 4.2 per cent[1,2] in all but a few of the larger hospitals and teaching centers in this country. This correction is obtained by excluding all cases of prematurity, previability, and developmental abnormalities. Thus breech delivery still entails a fetal risk four times that of cephalic delivery. Also, the fetal mortality is much higher when infants weighing less than 2,500 grams and more than 4,500 grams are delivered as breeches rather than cephalically.

Autopsies on fetuses (not exhibiting congenital anomalies) that died during breech delivery or within the first two neonatal weeks have shown, in 40 per cent, that death resulted from cerebral hemorrhage, in 18 per cent from asphyxia, in 16 per cent from "unknown cause," in 8 per cent from prolapse of the cord, and from bronchopneumonia, cerebral edema, and stillbirth of unknown cause in 4 per cent each.[2] In Calkins'[3] recently reported series of breech deliveries nearly half of the infants (again excluding the congenital anomalies) died of "trauma," prolapsed cord, or "unknown cause."

While there has been no demonstrable increase in maternal mortality with breech (as against cephalic) delivery, the maternal morbidity associated with breech delivery is from 8.5[2] to 9.9[4] per cent, representing, therefore, about a four to five-fold increase over that of cephalic presentation. The morbid factors most commonly present are urethritis, cystitis, pyelitis, thrombophlebitis, infected and disrupted episiotomies, and endometritis.[2] The maternal morbidity in breech extraction was 18.4 per cent, while in spontaneous and aided breech deliveries it was only 5.3 per cent; 10.3 per cent of primiparae having breech delivery were morbid, while only 6.9 per cent of multiparae were so troubled.[2]

Prolonged labor occurred in 8.7 per cent of Schmitz's series of 1,512 breech deliveries,[2] which is an incidence several times greather than the average, and one-fifth of all the fetal deaths in his series occurred in the prolonged labor group. A particular danger of prolonged labor in breech presentation is the inability to judge accurately when dystocia is due to fetopelvic disproportion. Thus we see that breech delivery offers some very real problems, and, despite widespread improvements in general obstetric care, and some real lowering of the fetal mortality rate in breech delivery in recent years, we are still faced with the fact that it is about four times more fatal for the infant and four times more morbid for the mother than is cephalic delivery throughout the country as a whole.

In view of the serious prognosis for the baby, breech presentation should be corrected to cephalic presentation before term whenever possible. This can be done by external version, a procedure which is easily carried out in the office with no discomfort to the patient. While the majority of the teaching centers in this country neither teach nor advocate external cephalic version for the correction of breech presentation, quite a few do so, and in the hands of the obstetricians there it has been shown to have no discernible risk to mother or infant and is accepted as good obstetric practice. It is certainly true, on the other hand, that if a totally inexperienced physician attempts to turn an infant in an unknowing and nervous manner, he may very well cause some separation of the placenta.

Ryder[5] reported having done external cephalic version personally in 290 cases in a series of 1,700 private patients, and stated that not one fetus could be shown to have suffered any harm. Adair[6] published collected statistics on 1,105 attempted external versions done by nine obstetricians and found that vaginal bleeding occurred

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Presented, by invitation, at the Michigan Clinical Institute, Detroit, March 9, 1956.

in only two instances, presumably from slight placental separation, or rupture of a small marginal sinus. In a report from the Boston Lying-in Hospital, Newell[7] presented data on 793 patients in whom breech presentation was detected in the third trimester of pregnancy. In all, 1,161 external cephalic versions were attempted, or 1.46 versions per case. Successful turning of the fetus was accomplished in 829 cases, or 72 per cent; spontaneous recurrence of breech presentation following successful external version occurred in 27 per cent of cases, and was again corrected each time. Including the 108 instances of spontaneous cephalic version which occurred in cases in which attempted external version had been unsuccessful, only 10 per cent of the original group of women arrived at term still with breech presentation. The fetal mortality for the series was only 2.9 per cent, as against the usual figure of 4.2 per cent.

The author was taught to perform external version at the Boston Lying-in Hospital, and has always practiced it, having succeeded in turning about 75 per cent of all breech-presenting infants in thirteen years of practice, and this without encountering any known vaginal bleeding or other real difficulty. A few of the infants that were successfully turned, to be sure, had to be turned back at once the way they had come to their original breech presentation because of some slowing of the fetal heart. This occurs, presumably, because of compression of the umbilical cord in their new cephalic position, but the reverse version is easily done and the fetal heart has always picked up immediately and regained its normal rate without mishap.

The author has delivered only three infants by the breech in his private practice in the past seven years. In all three, attempted external version was unsuccessful because the breech was frank, low, and engaged from practically the twenty-eighth week of pregnancy on until term. In one case there was a large baby, and corporopelvic disproportion was evidenced after a few hours of labor, so section was done. The other two, both primiparae, required extraction. All three infants survived. The making of routine attempts at external version of all infants presenting by the breech, starting at twenty-eight to thirty-two weeks of pregnancy, and the repetition of the version whenever the fetus returned to its original breech presentation, has decreased the incidence of breech delivery almost to the vanishing point in the practices of many obstetricians. The infants, in primigravidae, must be turned not later than the thirtieth to thirty-second week, in most instances, lest the breech become too deeply engaged in the pelvis to be dislodged; women having their second viable infant had best have version not later than the thirty-second week, and those having their third or fourth child can usually have the fetus turned anytime up until six to four weeks of term. I have, on one occasion, successfully performed external version between one uterine contraction and the next, in early labor, in a para-5 whose membranes were still intact, and who had a large baby and only an average-sized pelvis.

A knowledge of the position of the *in situ* placenta in the uterus is very important before one attempts external version. This is so because the placenta must not be handled or compressed during performance of the maneuver. In breech presentation it has been shown by the author[8] that the common position of the placenta, in single pregnancies within eight to ten weeks of term, is in one uterine cornual region or the other, and that this placental implantation site is the basic cause of breech presentation. If the fetal head lies in the right cornual region, then the placenta will be found filling the left cornu, and thus external version can be performed without manipulation of that cornu which contains the placenta.[9] When in doubt as to the existence of breech presentation, we always take a single anteroposterior, soft-tissue x-ray picture. Before performing external version we have the patient empty her bladder and lie on her back on the examining table with one or two pillows under her head and shoulders and another placed beneath her knees. We explain that her baby is presenting by its buttocks and that we are going to gently "turn it around so its head will come first." Talcum powder applied to the patient's abdomen permits freer movement of the operator's hands over the abdominal skin in applying the necessary pressure to the poles of the fetus. The pressure applied should be firm, steady, and gentle, and should be made by the flat of the hand and not by one or two fingers. We carefully auscultate the fetal heart before turning the fetus, and then auscultate it again as soon as the fetus has been placed in cephalic presentation. If the

heart is not entirely normal in the new position after one minute, the infant should be turned back, retracing the way it came around, to its original breech position. In our experience, when seen the next week, sponstaneous cephalic version has occurred safely in the meantime in most of such cases.

The first step in performing the version is to dislodge the breech from the pelvic inlet, and to move it upwards on that side which will cause the infant to turn in the direction in which it is facing. If, for example, it lies in LST position, and its head is in the right cornu of the uterus, we would move the breech up along the left lateral wall of the uterus so as to rotate the baby in a counterclockwise direction. The operator, with his other hand, then grasps the infant's head and brings it down along the right lateral uterine wall, placing it finally in the midline over the pelvic inlet. This manipulation can be done safely as long as one *does not attempt to handle any fetal part if any of the placenta lies between his hand and that part.*

It is our belief that the principal danger one encounters in doing external version, namely, traumatic separation of the placenta, can be eliminated by determining in advance the placental implantation site in each case and by strictly avoiding the handling of that portion of the uterus which contains the placenta while manipulating the fetal poles. Palpation alone will disclose the fetal head in one side or other of the uterine fundus, and the placenta will then be in the opposite side. Soft-tissue x-ray placentographic films will show the location of the placenta and the exact position of the fetus.

Anatomic factors which in general may make the performance of external version difficult or impossible are: bicornuate uterus, primigravidity, frank breech with extended legs, early deep engagement of the (usually frank) breech, oligohydramnios, "extended attitude" of the fetus, and undue elongation of the amniotic sac resulting from relatively low and lateral implantation of the placenta in the cornual region it principally occupies. When external version *cannot readily be accomplished* (due to inability to disengage the breech from the pelvic canal, or when the infant cannot easily be turned after the breech has been moved up into one iliac fossa) *it is best to desist in one's attempts to turn the infant.* Our experience has shown that about two-thirds of such fetuses will have undergone spontaneous version when seen in the office one or two weeks later. Real force should never be resorted to in the performance of external cephalic version, and it will rarely be necessary if the version is attempted before the fetal size has increased to that point at which the turning becomes difficult.

The contraindications to external cephalic version are: multiple pregnancy, history of vaginal bleeding, history of previous section, marked deformities of the fetus (such as hydrocephalus and anencephalus), ruptured membranes, and marked pelvic contracture making section a necessity. The generally accepted conditions under which external cephalic version is permissible and possible are: when the membranes are intact and at least an appreciable amount of amniotic fluid is present, when there is no polyhydramnios, when the breech is not too firmly engaged and too low in the pelvis to be safely dislodged, when a bicornuate uterus is not being dealt with, when placenta previa is not present, and when the anterior abdominal wall is not too obese to permit the necessary manipulations.

The probable reasons why more physicians do not perform external version are: (1) They are so skilled at breech delivery that their corrected personal fetal mortality rate is less than 1.5 per cent and they therefore do not feel any need to convert their breech presenting infants to cephalic presentation—this would account, however, for probably not more than 10 per cent of physicians practicing obstetrics; (2) they do not palpate the abdomen with the necessary accuracy required by the definite intention of disclosing breech presentation, nor do they do this at twenty-eight, thirty, and thirty-two weeks of pregnancy so as to discover breech presentation while it is still easy to perform external version (I have had several physicians tell me that by the time they learn that their primigravid and primiparous patients have breech presentation, the breeches are engaged and the infants cannot be readily turned); (3) there is a fear (ungrounded, in my opinion) that should they attempt external version they will dislodge the placenta or otherwise damage the infant. It is true that the same nervous hands which might exert undue suprapubic force on the aftercoming fetal head (accounting for most of the fetal cerebral hemorrhage found at autopsy), might cause some placental or fetal trauma when external version is attempted. The maneuver, to

be safe, must be done knowingly and gently by a physician who is relaxed and free of unreasonable fear.

Since all physicians practicing obstetrics must be able to perform a carefully and properly conducted breech delivery, most university teaching hospitals will not engage in any extended program of prenatal external cephalic version. Such is the case of Herman Kiefer Hospital, but external version is demonstrated here periodically so the residents will know the method, and its indications and contraindications. External cephalic version lends itself admirably to routine use by a private practicing physician.

The patient who has *uncorrectable* breech presentation and who is near term should have a careful study which will disclose the normalcy of the fetus, the adequacy of the pelvis, and the variety of breech presentation. These points can usually be determined by careful abdominal palpation and by sterile vaginal examination, but in case of doubt, roentgenographic studies should be made, both of the pelvimetry and placentographic types. If there are no contraindications to delivery through the birth canal, labor should be allowed to progress normally. *Mild* sedation, preferably wth Demerol®, should be given when good progress in labor has been achieved. It is essential that the fetal heart sounds be auscultated at regular periods and with increasing frequency as the second stage of labor progresses, because there is then an increasing liability of fetal circulation embarrassment due to compression of the cord. When dilatation of the cervix is complete and the breech descends onto the perineum, the patient should be encouraged to bear down with each contraction. As soon as there is the slightest bulging of the perineum, we prefer to perform bilateral pudendal nerve block, after the method so well described and pictured by Klink,[10] by injecting 4 to 6 ccs. of 1 per cent xylocaine solution at the mouth of Alcock's canal on each side. As soon as further bulging of the perineum occurs, we make a generous left mediolateral episiotomy, as this greatly aids the continuing extrusion of the breech through the vulva. In the spontaneous delivery, the passage of the shoulders and the aftercoming head should be aided so that a good mechanism can be maintained. Light inhalation anesthesia may be desired by some during the last two or three minutes of the second stage of labor, but we customarily do not use it as the patient has been told in advance that we may push on her lower abdomen "to help the head through." An effective pudendal nerve block has proven completely adequate in such cases in our hands.

In most breech labors, following blocking of the pudendal nerves and making the episiotomy, natural delivery to the umbilicus will take place under the watchful eye of the waiting physician. At this point we begin manual support of the infant's breech and trunk, keeping the back upward while rotating the trunk gently from side to side, if need be, so as to insure easy delivery of first one and then the other scapula. We always have a scrubbed assistant, and we have him hold the trunk upward at a 45-degree angle from the horizontal plane while the operator eases out the aftercoming head. In some multiparae, as is well known to all who practice obstetrics, the entire infant may be extruded so rapidly that the obstetrician is busy supporting it and making sure that it does not fall in his lap.

In frank breech cases, particularly in primigravidae, the operator may have to assist to a considerable degree, even applying mild traction to the breech with his index fingers gently inserted in the groin on each side. This aids in guiding and helping the passage of the breech through the vulva. He then should rotate the breech so that the infant's back is uppermost, and may support and apply gentle traction on the pelvic girdle, drawing the thorax through the vulva. As soon as the lower border of the thoracic cage starts to come through the vaginal outlet we commence rotations of the trunk, drawing the thorax through the vulva as we do so. Grasping half of the pelvis in each hand, with our thumbs over the sacro-iliac region on each side, we make the rotations of the trunk and thorax—clockwise, and then counterclockwise—through an arc of a little more than 180 degrees, each time bringing one or the other of the scapulae up to the anterior midline of the outlet, as denoted by the symphysis pubis. We also apply gentle traction, and keep the infant's back upward, or nearly so. In this way, first one, and then the other, of the scapulae are brought under the subpubic arch, and the occurrence of a nuchal arm is nearly impossible as the infant's arms, because of the thorax rotations, are kept moving about freely *in utero* beside its head up until the moment of their delivery.

We usually deliver the head by the applica-

tion of gentle suprafundic pressure made with the palm and heel of the hand, and not with the finger tips or knuckled fist. If the head does not descend readily to the pelvic floor with this pressure, and if it does not then come through the vulva without undue traction on the trunk or pectoral girdle, Piper forceps are applied at once. They are always kept sterile and in readiness in every breech delivery so that there is no question as to their immediate availability. They must be applied gently to each side of the infant's head, and we feel that this can best be done by putting the tip of the left blade inside the vaginal orifice and then moving its handle over against the under surface of the patient's flexed and draped left thigh. By guiding the tip of the blade gently around the side of the head with his left hand, and gradually swinging the handle of the blade through a 90° arc in the horizontal plane with his right hand, the operator can usually apply the left blade without trauma or difficulty. The same principle is then used with the opposite hands in applying the right blade. Pudendal nerve block anesthesia has proven adequate for forceps delivery of the after-coming head in most cases in our hands.

The head must be manipulated so that it enters the pelvic canal and comes down through it and delivers. If it cannot be readily brought down through the canal with suprapubic pressure alone, then the operator should gently insert his index finger in the infant's mouth and also exert light traction. With an assistant holding the infant the operator can use one hand to exert the pressure above and the other for traction below. This dual maneuver will generally bring the head down low enough in the canal to permit the safe application of Piper forceps. When the head is high and not even engaged, it is no safer to apply forceps (to the aftercoming head) than when they are applied to an unengaged head in cephalic presentation; the head should at least be brought down to about the mid-pelvic level before forceps are applied.

Single and double footling breeches deliver more readily and spontaneously than do frank breeches, but they carry higher incidences of prolapsed and compressed umbilical cord. One hopes, in single and double footling breech cases, that labor will progress to or nearly to full dilatation of the cervix before the membranes rupture, since following this event a leg frequently prolapses. Such an occurrence earlier in labor is undesirable since it decreases the size of the breech and thus permits it to pass through an incompletely dilated cervix, which may not dilate nor prepare the cervix adequately for easy passage of the aftercoming head. Rectal examinations during labor, in such cases, must be very infrequently and gently performed so as not to hasten membrane rupture.

In those patients having adequately large pelves and full dilatation of the cervix, in which there is inadequately strong labor in the second stage, or in primigravidae having resistant soft tissues and relatively large infants, or when there is evidence of fetal distress before the breech has appreciably bulged the perineum, *breech extraction* should be performed. Because breech extraction carries from four to six times the rate of fetal mortality as does spontaneous or aided breech delivery, it must be executed with consummate gentleness and skill. In those instances when there is frank breech presentation of an overly large infant, and there is only an average sized pelvis, particularly if labor has been prolonged and difficult and adequate progress is not being made, the idea of pelvic delivery had best be abandoned, section being performed instead. It is true that at section it is difficult to get the low, wedged-in breech back up out of the pelvis, but we have always been able to do so through a *longitudinal* (Kroenig) incision in the lower uterine segment without too much difficulty.

In performing extraction of the frank type of breech, we again use pudendal nerve block anesthesia, and then make a liberal left mediolateral episiotomy and quickly clamp and ligate the major bleeding points in it. We grasp the breech and pull it through the vulva until about half of the thighs are visible, if this is possible. Next we perform a Pinard maneuver on each leg in turn, exercising gentleness and slow caution so as not to further extend our episiotomy or to otherwise lacerate the vagina. We next place a dry towel around the pelvic girdle and, grasping one half of the pelvis in each hand and keeping the back generally up, we apply traction and commence the alternate 180° rotations of the trunk and thorax as described above. Sometimes the scapula will lodge just inside the base of the symphysis and not pass beneath it. We then gently insert an index finger above the scapula and deliver it and the shoulder from under the arch. Then the thorax is rotated 180° and the other scapula-and-shoulder is brought up under the

subpubic arch and delivered. The head in such a case, unless it comes out easily with suprapubic pressure, is delivered by Piper's forceps.

In a difficult breech extraction, we give the pudendal block anesthesia and make a wide mediolateral episiotomy, and if the breech fits snugly and cannot readily be brought down we prefer to supplement at once with ether and oxygen anesthesia, providing it is not contraindicated by reason of a full stomach or respiratory infection. If a competent inhalation anesthetist is not available, and there is a real need for uterine as well as soft-tissue relaxation, we then resort to spinal anesthesia and give the dose ordinarily used for section, such as 70 mg. of procaine injected through the third interspace with the patient lying on her side. Such ether or spinal anesthesia is essential in difficult extractions when there has been a long and difficult labor and there is reason to suspect the presence of a hypertonic uterus and possibly even a constriction ring. In all other cases we prefer pudendal nerve block anesthesia, which rarely may have to be supplemented for a few minutes with light nitrous oxide-oxygen anesthesia. We like to use pudendal nerve block principally because it permits the uterus to remain in full and unattenuated labor, and thus the percentage of spontaneous and "easy assist" breech deliveries remains at a maximally high (and, as the statistics indicate, maximally safe) figure on our service. We have the definite belief that the still strongly laboring uterus helps appreciably in expressing the aftercoming head, and that it is the wide use of pudendal nerve block anesthesia which has decreased our incidences of extraction and forceps deliveries.

The primary objective of Cesarean section in the management of breech presentation is to assure the birth of a living infant. Goethals[11] summarized 159 Cesarean sections done for breech delivery on 154 patients, five of whom were subjected to two sections, each with breech presentation. Aside from those common complications requiring section regardless of cephalic or breech presentation (e.g. diabetes, marked polyhydramnios, placenta previa, prolapse of cord, severe preeclampsia), he found the paramount indications for section to be: estimated fetopelvic disproportion, 71.7 per cent; elderly primiparity, 6.7 per cent; estimated oversize fetus, 5.4 per cent, obstruction of birth canal (ovarian cyst, uterine myomata, bicornate uterus) 2.7 per cent; and miscellaneous (e.g. previous myomectomy, prolonged labor, fetal distress, and failed pelvic delivery), 13.5 per cent. The incidence of breech presenting infants delivered by section at the Boston Lying-in Hospital prior to 1940 was 6 per cent, whereas since that date it has been 11.2 per cent; since 1940 the corrected fetal and neonatal mortality rate for breeches delivered through the vagina was 2.6 per cent, while for those delivered by section it was 2.3 per cent, all of which is a marked improvement in fetal survival over that of the period prior to 1940. X-ray pelvimetry, plus relatively accurate estimation of fetal size, permits a more knowing and valid anticipation of fetopelvic disproportion, and thus the decision as to the necessity of section is more readily reached; section thus resorted to produces an increased fetal survival.

A reduction of the fetal mortality in breech delivery to a corrected incidence of 2.5 per cent or less throughout our country is an important and attainable goal towards which obstetricians should strive.

Summary

1. Breech delivery carries a four-times-greater fetal mortality rate than does cephalic delivery, and also a four-times-greater rate of maternal morbidity. This is true of the country as a whole.

2. Breech delivery can be obviated in all but about one-fourth of the cases by routine external cephalic version of all breech presenting fetuses found, by a regular program for detection, at twenty-eight to thirty-four weeks of pregnancy. The corrected fetal mortality, in skilled hands and under such a plan, can be reduced to 1.5 per cent or lower.

3. External cephalic version, when gently performed, by knowing and careful physicians, carries no detectable incidence of fetal or maternal trauma or loss. It is a relatively easy maneuver, and can readily be learned from one experienced in its performance.

4. Breech delivery is best accomplished spontaneously, or by a single "assist," under pudendal nerve block anesthesia through a wide mediolateral episiotomy, and cases so delivered carry the lowest rates of fetal mortality, and fetal and maternal morbidity.

5. When a difficult frank breech extraction is to be done, ether anesthesia may be indicated, and

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Shoulder-Hand Syndrome

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THE SHOULDER-HAND syndrome is characterized by a painful shoulder, stiffness, swelling and pain in the hand and fingers, as a result of a reflexed neurovascular dystrophy following diseases of the thorax, head and neck. This condition may be seen after myocardial infarction.

At first, the pain in the extremity is accompanied by stiffness and swelling, eventually there may be atrophy with flexion deformities of the fingers and contractures with osteoporosis in some cases.

The shoulder-hand syndrome may follow myocardial infarction. It is usually not present in the acute phase, appearing two to three weeks after the infarction. Increasing stiffness of the upper extremity with pain in the shoulder and the hand and swellings of the hand are noted. This is followed by increasing disability, if something is not done to help cure the disease. No segmental sensory loss is noted. The tendon reflexes are intact, early.

Mechanism

The mechanism of production of the shoulder-hand syndrome is on a reflex basis. The afferent stimuli coming from the injured or diseased area in the thorax, or neck or the upper limbs activate the internuncial pool in the spinal cord. This then spreads to the anterolateral column stimulating sympathetic cell bodies as well as the cells in the anterior horn. The preganglionic fibers in turn activate the postganglionic fibers supplying the blood vessels of the extremity, resulting in a series of abnormalities, namely, stiffness of joints, swelling, and aching and burning pain in the hands and fingers (Fig. 1). It is important to remember that such reflex dystrophy may occur not only as a result of myocardial disease, but also as a result of other diseases in the chest and the mediastinum, as well as painful conditions in the

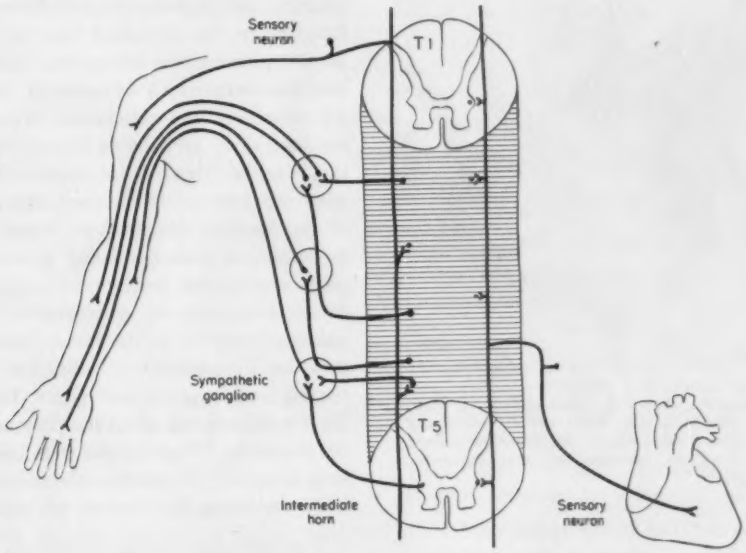

Fig. 1. A working outline of reflex pathways resulting in shoulder-hand syndrome.

From Wayne State University Neurosurgical Services, Grace and Memorial Hospitals, Detroit.
Presented at the Michigan Clinical Institute, Detroit, March, 1956.

upper extremity itself. The mechanisms for the causation of the neurovascular dystrophy and the reflex arc aiding in its causation are available through afferent discharges from the painful area

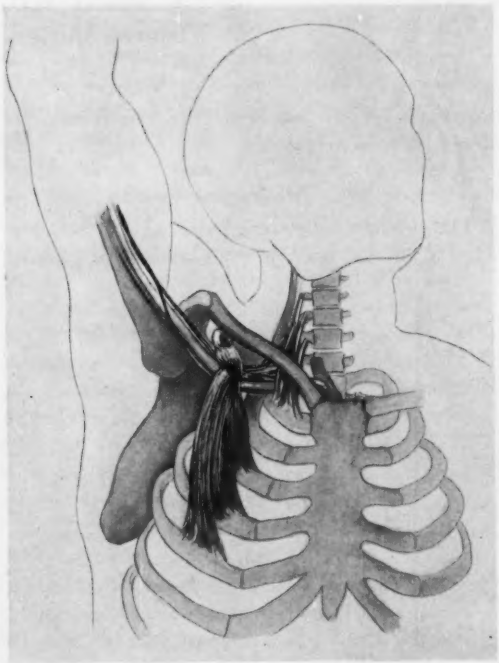

Fig. 2. This diagram shows the mechanism of compression of the neurovascular structures (subclavian vessels and the brachial plexus) by the anterior scalene and the pectoralis minor muscles, as well as costoclavicular compression.

into the internuncial pool in the spinal cord with sympathetic discharges and painful swelling with aching and burning.

Differential Diagnosis

The differential diagnosis of shoulder-hand syndrome includes a consideration of many of the conditions that result in a painful state in the upper extremity, that is, in the shoulder, hand, or both. These include cervical ruptured or protruded disc, Sudeck's atrophy or painful osteoporosis with bone atrophy, cervical rib and anterior scalene syndrome, costoclavicular syndrome, hyperabduction or subcoracoid syndrome, or pectoralis minor syndrome, causalgia due to nerve injury and local diseases in the upper extremity and the spine, including bursitis and osteoarthritis of the spine and the extremity.

The cervical rib syndrome is usually seen in the female patient in more than 75 per cent of the cases. Only a quarter of those with cervical rib or long transverse processes of the seventh cervical vertebra have symptoms. There may be sensory, muscular and vascular abnormalities with the pain usually from the elbow down. Aching and burning and, at times, shooting pain may be complained of, with paresthesias in the fingers. Often the ulnar portion of the hand is more involved. The pain is usually made worse by pressure in the supraclavicular area in the region of the emergence of the lower portions of the brachial plexus. Hyperesthesias and anesthesias associated with pain may be noted. Wasting of muscles, particularly in the thenar eminence is frequent in the untreated cases of long standing. At times there may be unusual pulsations in the supraclavicular area because of an upward displacement of the subclavian artery due to the cervical rib. Depending upon whether or not the brachial plexus is of the pre-fixed or of the postfixed variety, there may be more involvement of the median distribution in the former group as compared with the latter group in which the ulnar distribution is more frequently involved. At times there may be a feeling of coldness with pallor or cyanosis in the hand. Occasionally there may be intermittent claudication with the extremity red, swollen and livid. The diagnosis of the condition is based on the presence of a cervical rib shown by x-ray and the symptoms. When the head is turned toward the affected side and posteriorly, there may be a loss of the radial pulse.

The anterior scalene syndrome is caused by compression of the lower brachial roots forming the brachial plexus and/or the subclavian artery by this muscle. A hypertrophy of the anterior scalene muscle may compress the brachial plexus and the subclavian artery. An obliteration of the pulse may occur on turning the head toward or away from the affected side or there may be increase in the symptoms and signs by these maneuvers. There may be tenderness of the muscle on compression and relief of the complaints by elevating the shoulder girdle. Injection of procaine into the belly of the muscle may help relieve the condition. In some cases, the vascular symptoms of a tight anterior scalene may be quite serious with marked color changes in the hand, in some even a gangrene of the distal portion of the extremity may be noted. A swollen hand

with shiny skin of the fingers and hand, difficulty in flexion and extension of the fingers, pain in the extremity, may be in part due to the compression of the vessel and nerves and in part due to reflex vasomotor abnormalities from activation of the internuncial neurons in the spinal cord and the sympathetic pathways (Fig. 2).

The subcoracoid or pectoralis minor syndrome or hyperabduction syndrome is due as the name suggests it, to hyperabduction either in work or sleep with neurovascular changes associated with pain in the hand or shoulder, at times Raynaud's phenomenon, paresthesias involving the entire hand. The kinking of the subclavian vessels and the brachial plexus by the edge of the pectoralis minor results in the neurovascular abnormalities (Fig. 2).

The costoclavicular syndrome is caused by a compression of the subclavian artery and the brachial plexus between the first rib and the clavicle. An abnormal sagging of the shoulders with a high first thoracic rib may result in this syndrome. Hyperextension of the neck or backward pulling of the shoulders may compress the brachial plexus and the subclavian vessels between the clavicle and the rib. The diagnosis may be made on the basis of these maneuvers and the presence of abnormal x-ray findings suggesting such a condition.

Causalgia due to partial injury to one of the nerves in the upper extremity is associated with burning, aching, crushing feeling, paroxysms of shooting pains. In instances of amputation neuroma, there may be pains in a phantom limb, which according to the patient, is in a fixed, immovable and cramped position. Causalgia associated with partial injury to the nerves may be associated with a constant burning, aching pain, with severe exacerbations on physical and emotional stress. The hand may be cyanotic and wet; in other instances, it may be dry and scaley. More frequently, it is cold and wet with perspiration. Eventual atrophic changes of the nails, and a thin, shiny, hairless epidermis may be seen. In many instances a beginning causalgic state may improve early after its inception, but in others the condition continues, to become an unbearable state. Sympathectomy has been of value in this condition.

Sudeck's atrophy may often follow fractures of bones and in some cases insignificant injuries to an extremity. Spotty decalcification of the bone with vasomotor disturbances and great pain in the extremity are the diagnostic features of the condition. Early there may be a swelling and discoloration and intense pain with local vasodilation. Later, the hyperemia may be followed by vasospasm and a glossy skin with edema and cyanosis in the dependent position. Sympathectomy is valuable in management.

A cervical disc may or may not be associated with a history of trauma. Evidences of focal sensory changes in the upper extremity and in some cases with loss of biceps and/or triceps tendon reflexes are noted. The diagnosis may be based upon the history of pain in the neck and radiation into the upper limb. The movements of the neck may cause radiations of pain in the affected limb. The use of a cervical myelogram and the presence of narrowed cervical intervertebral spaces are valuable in diagnosis.

Diagnosis

The diagnosis of the condition is based on a careful neurologic examination following a meticulous history. The use of x-rays of the cervical spine and the extremities and myelography may be of help. In some cases, the possibility of two conditions occurring simultaneously should be kept in mind. This is particularly true among those with hypertrophic osteoarthritis of the cervical spine who may also have a myocardial infarction followed by a shoulder-hand syndrome.

Treatment

The treatment of the patient with shoulder-hand syndrome is by the use of sympathetic blocks, physiotherapy, massage, active and passive movements of the extremity as well as the development of a healty viewpoint toward one's disability. Since many of these patients are in the older age group, the last-mentioned factor, that of the emotional instability toward one's disability, is extremely important. To help overcome this is an important part of the treatment of such cases. Where definite disease entities have been found which may be treated by special measures such as sympathectomy, laminectomy, scalenotomy, et cetera, these should be carried out.

Editorial

CHILD WELFARE ISSUE

This issue of THE JOURNAL is sponsored by the Child Welfare Committee of the Michigan State Medical Society. The term "Child Welfare" bears an unfortunate connotation. "Welfare," to most people, suggests social need and charity rather than the physical and emotional well-being of all. There are those who may feel that this issue, dealing with children, is so restrictive as not to concern them. We all, though, are concerned with standard of living, and recently our standard has risen greatly because of the improvement in child health.

The health of no group is more before the public's eye than that of children. The medical profession gets credit when there are advances—as in perinatal morbidity, with the reduction of retrolental blindless by limiting use of oxygen, or with survival of infants with erythroblastosis by replacement transfusions. Contrariwise, we are criticized, usually vehemently, when there is some breach in child care. Our critics do not think of us as individual doctors but as a professional group. We are praised or dammed as a group. By force, then, all of us, must be deeply concerned with "child welfare."

Selection of an appropriate cover for a journal is always a problem. I felt the little princess we chose rather breath-taking; you can't help but look at her twice. Regardless of our critics and standards of living and medicine, her attraction to us demonstrates the instinctive love of children we all have.

The child is the daughter of John Cook, and the picture was taken by George Jennings, both staff members of the State Department of Health. Choosing this picture was appropriate and manifests again the constant co-operation of assistance given us by the State Department of Health.

Another cover was suggested, depicting "Operation Armor," symbolizing the State Medical Society's campaign to get all susceptible persons vaccinated against polio, regardless of age. Here the borderline between child and adult welfare breaks down. The articles on polio, important to us all, emphasize that we each, by every possible means of education, must not only "get the vaccine to the patient, but get the patients to the vaccine."

How many of our own children needed glasses before we doctors, the children's fathers, were aware of it? The vision screening tests performed in schools throughout Michigan have revealed many preventable or correctable eye conditions. Might our own vision today have been better had our eyes been tested when we were younger? What should we be doing in our offices to check vision?

And how many inquiries do we have each year about adoptions? Did you know that in this state there has been no formal training of medical or law students in the medical, legal, and ethical factors of adoptions? Yet our patients expect us to be thoroughly conversant with at least the medical phases of adoption. Are you?

Other articles summarize some of the interests explored and conclusions reached by various members of the Child Welfare Committee and of others who have concentrated on child care.

The Committee is grateful to the State Medical Society for the opportunity of bringing these to your attention, and we appreciate the time and effort of those who have contributed to this issue.

ROBERT M. HEAVENRICH, M.D

PROPOSED NATIONAL LEGISLATION

The President's Health Legislation program has not yet been outlined to Congress but sufficient has been indicated to give us a good idea of what to look for. The Civil Service Commission has a program left over from the 84th Congress providing hospital and medical services for more than two million workers and their dependents. Last year, the Congress almost agreed on a plan which would give very liberal terms, the government paying the first $25.00 of the premium. It proposed that payroll deductions be authorized. This last item was one reason the bill did not pass. A commission was authorized to study its feasibility. Government feared the workability in its

(Turn to Page 358)

Kids Are Important

In matters of Health, nothing has comparable public appeal to the physical vicissitudes of children.

You and I know that the child is probably as indestructible a human as any in existence, and that, barring accidents, he's going to live longer than any of the folks who worry about him.

On the other hand, the old adage "as the twig is bent, the tree is inclined" is perhaps truer in respect to physical and mental health than it is to any other part of the child's life, insofar as his future well-being and success are concerned.

Consequently, it behooves us, as doctors and as medical societies, both from the standpoint of good preventive medicine and good public relations, to put increasingly strong emphasis on the health welfare of children.

And that is what we are doing. Our all-inclusive immunization campaign called "Operation Armor," our Rheumatic Fever Control program, the statewide studies of sight and hearing in the schools, the programs for crippled and afflicted children, the child guidance clinics—all are manifestations of the medical profession's interest in children.

It strikes me that there is another reason why "kids are important" and why we have a duty, not only as doctors but as citizens, to do our part in seeing that America's children grow straight and tall and sound. It is that our national defense, the future progress of our country, the maintenance of a straight-thinking electorate, indeed, the future of our profession all depend on the "twig" that is so easily bent.

It's quite a responsibility.

President's Message

Arch Walls M-D

President, Michigan State Medical Society

own affairs; however, in formulating income tax regulations, they had no hesitation to impose withholding duties on industry.

The plans being considered for medical and hospital "insurance" for government employes seems to be favorable to the Blue Cross and Blue Shield methods. A uniformity of contract is favored by some, but the Blue Shield can overcome the differences in its seventy-four plans by using its own reinsurance plans to cover items not inincluded in some plans. The Blue Shield plans have the advantage of really representing the requirements and facilities to which the people and doctors of the section are accustomed. General Motors has worked out this problem very satisfactorily.

The President has been concerned with more services for uninsured and uninsurable persons. There are now about 14,000,000 persons over sixty-five who are retired or are being retired—some with social security but most with inadequate resources. Of these, the government has grouped four service programs in a special category: Aid to Blind, Old Age Assistance, Dependent Children, and Disabled.

From time immemorial, the state has had the responsibility of feedings, housing and clothing the indigent. Niggardly medical care also has been provided to the "medically indigent." The Federal Government has borne part of this cost. It now provides matching funds to the states. For several years, the four groups mentioned have been included, but the last Congress in an effort to improve care, authorized a special grant of $3.00 for each adult and half that amount for each child under nineteen with matching funds from the states, to give additional medical aid to the four classifications. The Michigan Department of Social Welfare is considering using the children's share for dental care, and the adult share for increasing hospital services.

Indigent Care

There are many people unemployed, unable to work, or just unemployable who must have health care. These are part of the President's candidates for "reinsurance." Our Michigan Welfare department is paying those on its rolls $3.00 a month for miscellaneous medical care and a limited allowance for doctor's bills, provided they get a doctor's signature on their form each month. The patient is supposed to pay the doctor, and more are now doing so; however, this whole program is cumbersome.

One county in Michigan, some years ago, offered to contract for the necessary care of all the indigents for the exact amount they were costing the welfare agencies, the county society agreeing to pay the doctors. It was believed that complete care could be given for the current costs. That plan was blocked by rulings that the Welfare Department must not pay direct for health care.

Another scheme suggested was a "cost-plus" basis—the Department to authorize care and pay for it through an intermediary (MMS). That seemed most logical—government has the responsibility of health care for these people—the plan could work. It has worked in several of our states in care of service-connected disabilities of our veterans. The same program is now in operation throughout the United States for the dependents of military service personnel.

Blue Cross and Blue Shield over the nation have indicated their ability and willingness to care for the uninsurable and the worthy wards of the Government. The last groups mentioned herein are historically admitted to be the responsibility of government. Available sponsors have always been the charity hospitals and the sympathizing doctors. The voluntary health service plans have pointed the way, and government should accept its responsibility. So far, the only cost to the government has been administrative, because we have used our own set-up at cost. Government has suggested subsidies to cover the plans we have been discussing. The Blue plans do not want any subsidity but would be willing to work on a "cost-plus" arrangement.

Jenkins-Keogh

Another piece of national legislation is the renewed Jenkins-Keogh bills, again numbered 9 and 10. They have been modified but in general provide for the assigning of part of income, up to a limit, which can be invested in approved methods to build up a retirement program, to be tax-free until the funds are drawn upon for retirement purposes, at which time they will be taxable in a reduced amount. The bills propose to allow self-employed men the same tax-exempt formula now being used by industry to establish endowments for its employed persons. This bill now has the support of the American Bar Association and hopefully will be remembered by our

representatives when the time of action comes. Last year, it might have been enacted. Let's see that it is enacted this term.

Murray-Dingell

Congressman Dingell, son of our former representative from Michigan, has joined with Senator Murray so that in each House a bill much like our old friend of fourteen years ago has been introduced. Many items of the original bill have been enacted piecemeal during the years. We now have education and health personnel; medical research; Hill-Burton hospital construction (expanded); aid to rural and shortage areas; state grants (matching) for health work; grants for national health; grants for child welfare.

The Dingell-Murray scheme is similar to social security, establishing a system of health insurance requiring workers to contribute 1.5 per cent of earnings up to $90 a year, matched by employers. Eligible workers and their families would receive preventive and diagnostic examinations, x-ray and laboratory, hospitalization up to ninety days, more expensive drugs, appliances, glasses. This practically covers the field for all employed persons.

PREPAYMENT

Great proportions of our members are happy in the service we have been able to render our patients because of our Michigan Medical Service. Too many have accepted returns for services to patients, have been critical of the amounts of payments, and in general have critized "that insurance company." We have heard it for years, Unfortunately, many do not remember the time before "prepayment." The man who collected over 75 per cent considered himself a good businessman. The effort and time consumed in collecting amounted to a staggering amount. That is all gone with Michigan Medical Service. No collecting expense, only one detailed report necessary, and a rather prompt check. At its inception Blue Shield had its most important purpose to guarantee health services to a large proportion of our patients who were primarily in the lower income bracket, and to whom a trip to the hospital was a calamity. The hospital, the doctor, the grocer, all had to wait. Unfortunately, too many of us do not respect Blue Shield as our own child, our best friend, our guard in former years against socialized medicine of the Wagner-Murray-Dingell type.

A new Murray-Dingell bill is now in the hopper, but our watchful medical leaders are much more concerned with a threat to the time-honored system of private practice of medicine. Some attempts have been made to put groups of the profession on a salary or capitation basis, but not too successfully. The older doctors in Detroit remember the consternation when the Ford Hospital instituted its work through salaried doctors. Some remember the Ross-Loos Clinic of California. The Kaiser Permanente NTI plan caused concern and much readjustment in California. HIP in New York City uses capitation.

Because Michigan has very few groups or clinics, and not much experience with that type of practice, we were taken aback with the announcement of the Community Health Association, and its announced intention of employing doctors on salary, for the care of their insured people. Should the plan grow and need large numbers of doctors, that would place our profession, in large measure, in the position of contract practice, the union leader being the dictator of care and loyalty. The CHA Board has stated its intent never to interfere in the professional services. How long will that promise last when the employer is the creature of a most powerful pressure group?

The Council of the Michigan State Medical Society believes this threat to private practice can be countered by two concerted efforts. First, Michigan Medical Service is offering more complete coverage as a rider. The service can be rendered at a surprisingly small price, but it must be paid for. Those services cannot be given free. Second, it will probably be necessary for all of our members to accept the offerings of Michigan Medical Service and meticulously not overcharge the under-income-level persons. Savings on collection costs and loss from unpaid bills will probably amply overbalance the contemplated overcharges in the long run.

The most important advantage will be the protection of our right to practice medicine as we have in the past—placing our own peers over us instead of a government hierarchy, or a strong labor group.

Too much is at stake to take chances—all of us must co-operate.

WHAT MAKES BLUE SHIELD DIFFERENT?

One frequently hears doctors ask, "Isn't Blue Shield just 'another insurance company'?" This question usually comes from a member of the generation of new doctors who have come into practice since the early '40's, and who know little of the desperate challenge that gave rise to the Blue Shield idea and the hard work with which its accoucheurs gave it birth.

Blue Shield represents a vast and triumphant effort on the part of American medicine to prove to the people of the United States that, with their help, their doctors can solve urgent problems of medical economics without governmental interference or dictation. Blue Shield was created at a time when the insurance industry questioned the actuarial feasibility of voluntary medical care insurance on any large scale, and even many doctors feared that a voluntary program would inevitably lead to a compulsory health insurance system under government auspices.

Blue Shield has little in common with commercial accident and health insurance beyond the fact that it utilizes actuarial principles. Where the insurance company underwrites selected groups to produce a profit, Blue Shield, reflecting the service ideals of the medical profession, makes its services available to the entire community, at rates based on the needs and experience of the community—including most particularly those people in the low income groups who most need medical prepayment protection.

Where commercial insurance companies offer cash allowances which may or may not have any relation to the doctor's normal charge for his services, Blue Shield's schedules of payment are negotiated and approved by the local medical profession. In most areas Blue Shield benefits take the form of fully paid professional services, through the co-operation of the "participating physicians." Even where "service benefits" are not provided by formal agreement of the doctors, Plan schedules generally attempt to approximate the normal charges of the local physicians for services rendered people in the lower income brackets, and the local physicians frequently accept these fees as full payment.

Blue Shield Plans are distinguished by non-profit operation, which means that their only purpose is service to the people and their doctors. Non-profit operation also means that all the funds contributed by the subscribers are available for payment of benefits, with a minimum retained for actual operating costs and reserves for future claims.

Over and above all requirements of state law, Blue Shield Plans are required to maintain strict "membership standards" in order to use the name and symbol "Blue Shield." These standards provide that the Plan must have the continuous approval of the local medical society; must render an annual report to the society; and must secure the formal participation of at least 51 per cent of all the physicians in the Plan area.

Blue Shield utilizes insurance principles, but, because of the participation of the great majority of American physicians, it is able to transcend the limits of insurance—to become a true community service on behalf of America's physicians.

DEATHS BALANCE BIRTHS

Over the past thirty years, extensive maternal mortality studies have been carried on in Michigan. Due at least in part to the application of information obtained from these studies, the maternal mortality rate in Michigan has dropped 92.3 per cent. However, during the same period, deaths of newborn infants have declined only 55.8 per cent.

It is probable that one reason for this disproportionate decline in mortality rates is a lack of information and research regarding the exact cause of many perinatal deaths. Although definitions vary somewhat, the most commonly accepted meaning of the term "perinatal mortality" relates to the total fetal deaths from twenty weeks or more gestation and newborn deaths within the first seven days of life. If these deaths are to be reduced significantly, it is necessary to obtain complete and reliable information regarding the pregnancy, delivery, condition of the infant at birth, and treatment and care of both mother and child.

A number of Michigan physicians, concerned about fetal wastage as well as handicapping conditions in surviving infants, have organized committees to study perinatal deaths and factors associated with them. Included among the leaders in organizing such committees are physicians in Wayne County, Grand Rapids, Saginaw and Lansing. They realize that the perinatal period offers

one of the most fruitful areas for research and education, not only in terms of preventing deaths and disability but in saving taxpayers' money. A factor which causes the death of one child may cause a seriously handicapping condition in another who survives. Preventing such conditions from developing must certainly be considered as a primary purpose of these perinatal studies.

A perinatal mortality study committee usually includes general practitioners, obstetricians, pediatricians, pathologists, anesthesiologists and public health workers. Accurate and complete information on birth and death certificates and hospital records is the basic requisite for a valid study. In this, *all* physicians caring for mothers and newborn infants can co-operate. A uniform procedure for reporting data throughout the state is essential because it makes valid comparison possible and provides statistics of significance and value.

Assistance with the planning of such studies and standard forms for the tabulation of data and statistical analysis will be provided by the Michigan Department of Health upon request.

The need for such studies is highlighted by the fact that prematurity is the leading cause of death among newborn infants. In 1954, physicians stated on death certificates of infants under twenty-eight days of life that prematurity was the sole cause of 36 per cent of the deaths and an associated cause in an additional 26 per cent. It would seem apparent, then, that emphasis should be placed on the prevention of prematurity. Factors to be considered in such prevention are early and adequate prenatal care and the avoidance of surgical or medical induction of labor until maturity has been assured by radiologic or clinical means. When necessary, gestation can often be prolonged by judicious sedation and rest.

Of course, prematurity is often inescapable; some infants refuse to delay their arrival into the world despite the best efforts of all concerned. In such cases, death can often be prevented by thorough preparation before delivery for immediate care of the expected premature infant. This, of course, requires adequate hospital equipment and facilities, as well as highly competent medical and nursing care. In addition, instruction of the mother regarding the care of the infant in the home is extremely important. Many physicians routinely request home visits by public health nurses for premature infants and are convinced of their value in saving lives.

Michigan ranks high among the states in terms of quality of medical care, hospital beds, public health services and economic status. It is also fortunate in having so many physicians who devote much of their time and energy to public and community health. Yet, by a more effective co-ordination of these forces, a higher level of health for Michigan children can be attained.

This would include: greater participation by physicians in lay education regarding child health; research and studies of fetal wastage and handicapping conditions in children, both congenial and acquired; further improvement in hospital care, both in nursery facilities and pediatric departments; and better utilization by practicing physicians of the services and materials provided by the state and local health departments.

Certainly, there is still a great deal of room for improvement in further reducing perinatal deaths in Michigan. By establishing committees to investigate all known factors pertaining to perinatal deaths and by analyzing probably preventable factors which lead directly to these deaths or conditions contributing to death, it is not unreasonable to suppose that a significant reduction can be achieved.

GOLDIE B. CORNELIUSON, M.D., Director
Division of Maternal and Child Health
Michigan Department of Health

Careful perimetric studies are by far the best method of localizing occipital lobe tumors.

* * *

Significant alterations in the orbital veins, whether congenital or the results of pathological degeneration of the vascular walls, neoplasms or trauma, give rise to venous aneurysms.

* * *

The radioactive isotopes are among the more promising of the newer techniques for determining the location and demarcation of intracranial neoplasms.

* * *

There has been neither morbidity nor mortality traced to action of the radioactive dyes in tests for brain tumor localization.

* * *

Early brain tumors are often mistaken for chronic indigestion, migraine, mental illness, hypochrondria, or just plain laziness.

* * *

Any attitude of hopelessness in regard to brain surgery and its results is a distinct anachronism. Operative mortality rates have been greatly reduced and many patients permanently benefit from modern operative procedures.

L. Fernald Foster, M.D.

Servant and Director of Medicine

L. Fernald Foster, M.D., Bay City, will devote his full time to the carrying out of duties of his two offices—President of Michigan Medical Service and Secretary of the Michigan State Medical Society as Medical Executive Administrator.

Dr. Foster has been a member of the Board of Directors of Michigan Medical Service since its inception in 1939. For the past twenty years, he has been Secretary of the MSMS.

The list of Dr. Foster's activities in behalf of the medical profession seems endless. Here are a few highlights:

In December 1956, he resigned as Secretary of the Bay County Medical Society after a tenure in that office of thirty-six years. This tenure was broken only by a year of service to that organization in the office of President, during which time the Secretary's books never left his office. Recognized as an outstanding pediatrician in Bay City, he held at some time, during his years of practice there, every office of importance in the hospitals concerned with the medical staff or his specialty. At the same time, he served as a consultant in pediatrics in surrounding community hospitals.

His impact has been felt most, in spite of his outstanding record in his hometown, on the state and national levels. Known for many years as the man who was always aware of what was going to happen before it happened in medical society affairs, a plan to make him "President-for-a-Day" was successfully kept secret from him until the resolution was passed by the House of Delegates in 1954. He had deliberately refused any attempt to put his name up for the presidency on many previous occasions and had likewise refused to accept a chance to become a trustee of the American Medical Association.

He was told at that time: "With your ability there isn't any doubt in our minds that you'll be President of AMA." Said Foster: "But I don't want to be President."

His work with the Michigan State Medical Society includes activity in connection with nearly every committee and project of that organization and so are too numerous to mention. However, with his understanding of the medical profession as a springboard, he has inaugurated many a program and project which are now accepted as standard parts of the warp and woof of health services.

A founder of Michigan Medical Service, he is also a founder of the Michigan Heart Association, serving as its first Secretary and its present Vice President. He started the Michigan Rheumatic Fever Control Program when he was serving as a member of the Board of Directors of the Michigan Society for Crippled Children and Adults. He aided in the organization of the National Conference of Medical Service and served as its President. As Chairman of the Board of Directors of the Cooperative Medical Advertising Bureau of the AMA, he was influential in the establishment of the present, independent State Medical Journal Advertising Bureau, upon which he still serves as a member of the Board of Directors and Chairman of the Advertising Committee. With MSMS Past-President Andrew S. Brunk, M.D., he formed the Conference of Presidents and other Officers of State Medical Societies; and the list goes on and on.

Nor has his activity been limited to general phases of organized medicine. Although a front-line favorite of the general practitioner, he is a specialist. Following graduation from Lafayette College in Easton, Pennsylvania, with a Ph.B. degree, he received his medical degree from the University of Pennsylvania School of Medicine in 1919 and interned at the Presbyterian Hospital and Childrens Hospital in Philadelphia. He took

his residency in pediatrics at the Presbyterian Hospital and was Chief Resident of Childrens Hospital there. He took postgraduate work at Washington and Johns Hopkins Universities and became successively diplomate of the National Board of Medical Examiners, diplomate of the American Board of Pediatrics and member of the American Academy of Pediatrics.

Besides his wide activity in medical circles, he is a member of Rotary and several other fraternal organizations including the American Legion, the latter following his military record as a member of the Medical Reserve Corps in World War I.

Although his chief love is medical organization, his inquiring mind became intrigued with fire fighting. Today, he is an authority on fire-fighting equipment and installations, and his persuasive personality as a speaker has resulted in improvements in fire department equipment, not only in Bay City, but in several other Michigan communities.

He sees no disparity between his interest in medical organization and fire fighting, probably because he's put out many a fire that threatened his chosen profession and certainly has built a fire under many a slow-moving colleague when action was urgently needed.

As he goes into full-time service in MMS and MSMS, you can expect to see the same intensified, extensive programs take form that have characterized his past performance.

RUBELLA IN PREGNANCY

(Continued from Page 341)

stillbirths of 6 to 10 per cent, where maternal rubella occurs in the first sixteen weeks of gestation.

3. The effectiveness of gamma globulin in prophylaxis is questionable.

4. Many considerations deter the physician who considers therapeutic abortion.

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MANAGEMENT OF BREECH PRESENTATION AND DELIVERY

(Continued from Page 352)

great care and gentleness must be exercised so as not to damage the fetus or traumatize the mother.

6. In breech delivery, the episiotomy, in our hands, is best made under pudendal nerve block, or local, anesthesia in all cases. Following this, spontaneous or assisted delivery, also most breech extractions, can readily be performed. Additional or supplementary inhalation anesthesia is reserved for the most difficult breech extractions, and most forceps deliveries of the aftercoming head can readily be performed under pudendal nerve block anesthesia.

7. The use of x-ray pelvimentry, plus a relatively accurate assessment of fetal size, permits a more ready determination of anticipated fetopelvic disproportion, and thus the decision as to the necessity of section is more validly reached.

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Michigan State Medical Society

Annual Session of the Council

January 24-25, 1957

HIGHLIGHTS

- The Auditors' Report for the year 1956 and the budgets for 1957 were approved (see page 375).
- Annual Reports of the Secretary, Treasurer, Editor and Rheumatic Fever Coordinator were presented and approved. Reports of the three Standing Committees of The Council (County Societies, Finance, Publication) meetings of January 23, 1957, were accepted.
- Secretary L. Fernald Foster, M.D., Bay City; Treasurer William A. Hyland, M.D., Grand Rapids; Editor Wilfrid Haughey, M.D., Battle Creek, were reelected for 1957.
- Progress report on Michigan Medical Service was presented by L. Fernald Foster, M.D., President, and Jay C. Ketchum, Executive Vice President of Blue Shield; progress report on Michigan Hospital Service was given by Wm. S. McNary, Executive Vice President of Michigan Blue Cross.
- Annual reports of individual Councilors on the condition of the profession in their Districts were presented.
- Monthly reports of Council Chairman D. Bruce Wiley, M.D., Utica; President Arch Walls, M.D., Detroit; President-Elect G. W. Slagle, M.D., Battle Creek; Secretary L. Fernald Foster, M.D., Bay City; and Speaker K. H. Johnson, M.D., Lansing, were presented and accepted.
- Michigan Health Commissioner A. E. Heustis, M.D., Lansing, informed The Council on current problems in preventive medicine. The Council approved five items in the Michigan Health Department's budgetary recommendations to the 1957 Legislature including appropriation for polio vaccine; tuberculosis post-sanatorium care; follow-up for prevention of relapse of mental illness; appropriation for inspection of nursing homes; and migrant workers' health program. The Council specifically disapproved two other items: re establishment of consultant team in long-term illness; and home-care nursing programs. The Council took no action on the proposal re air-pollution control.
- Committee on Site for New MSMS Headquarters Building reported on various opportunities available in Lansing and environs, and was instructed to continue its studies.
- Home Town Medical Care Program.—Jay C. Ketchum, representing Michigan Medical Service which has served as intermediary for this program in Michigan over the last ten years, reported on a crisis resulting from recent VA regulation that practically cuts Blue Shield services to merely issuing payment checks. A committee of three (William Bromme, M.D., Detroit, Chairman; W. S. Jones, M.D., Menominee, and G. W. Slagle, M.D., Battle Creek) was appointed to study this matter, to attend an AMA-sponsored meeting in Chicago on the subject, and report to the MSMS Executive Committee of The Council on March 12.
- Beaumont Memorial.—Recent contributions to the Beaumont Memorial from members of the Michigan State Medical Society total $7,652.50. A vote of thanks to these generous donors was placed on the minutes of The Council.

- Dr. Harlan H. Hatcher, President of the University of Michigan, acknowledged receipt of MSMS letter containing the resolution recommending the establishment of a department of general practice in medical schools, it was reported.
- Final plans for organization of the Mid-Summer Session of The Council were presented and approved. To expedite the increased load of work, the session is being moved up twenty-four hours, resulting in a three-day instead of a two-day meeting, as in the past.
- Employment of a Scientific Director for the Michigan State Medical Society, as recommended in the Secretary's Annual Report, was approved.
- The President appointed the Tuberculosis Control Committee (an MSMS standing committee) as the committee to study excess tuberculosis beds in sanatoriums, in accordance with the 1956 MSMS House of Delegates resolution.
- C. E. Umphrey, M.D., Detroit, Past President of MSMS, was chosen as Chairman for Michigan of the American Medical Education Foundation, on appointment of President Walls.
- Michigan Crippled Children Commission Director Carleton Dean, M.D., Lansing, outlined mutual problems to The Councilors for their information and advice.
- Committee reports were presented by: (1) Iodized Salt Committee, meeting of December 14; (2) Arbitration Committee, December 28 and January 11; (3) Preventive Medicine, January 10; (4) Legislative Committee, January 10; (5) Tuberculosis Control Committee, January 11; (6) Medical Advisory Committee to State Department of Social Welfare, December 12 and January 20; (7) Joint Committee to Meet with Michigan Society of Neurology and Psychiatry and Michigan Psychological Association, January 2; (8) Committee on Michigan Medical Service, January 23; (9) Comprehensive Prepaid Medical Care Plans, January 11; (10) Medical Advisory Committee to Michigan Hospital Service, January 16; (11) Permanent Conference Committee, January 16; (12) Postgraduate Medical Education Committee, January 17.
- Immunization Procedures.—The Council reaffirmed its policy of furthering—through adequate publicity to the public—the value of polio immunization and all other immunization procedures through proper media.
- Report of S. E. Gould, M.D., of Eloise, re Code of Procedure and Ethics Relating to Autopsies, was presented and approved with thanks.
- Community Health Association.—Creation of this proposed "association" under sponsorship of the UAW-CIO, was thoroughly discussed. The MSMS Committee on Michigan Medical Service was authorized to develop whatever program it recommends and to communicate with the Speaker of the House of Delegates to call a special session of the House, when ready.
- Program for the MSMS County Secretaries-Public Relations Seminar of January 25-26-27, in Detroit, was presented and approved.
- The Council congratulated the Michigan Cancer Coordinating Committee on its new brochure "Strength Through Unity Against Cancer," for lay distribution.
- The Home-Visit Program of the Pediatrics Department, University of Michigan, was approved—subject to approval by the county medical societies in the areas where this program is to be used.
- Public Relations Counsel's monthly report included factual data on legislation; polio immunization publicity campaign; health exhibits at state and county fairs; *Parade* article by President Walls; and January 17 meeting with practicing pharmacists and representatives of Michigan Board of Pharmacy on a legal matter.

SECRETARY'S ANNUAL REPORT—1956

TO: The Council of the Michigan State Medical Society:

I herewith submit the annual report of the Secretary for the year 1956.

MEMBERSHIP

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I must regretfully report a total of one hundred ten deaths among members during the past year.

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Lapeer County—Henry G. Merz, M.D., Lapeer.

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1956 ANNUAL SESSION

Once again records of attendance were broken and the 1956 Annual Session chalked up a total registration of 4,290. The figure includes Doctors of Medicine 2,454; Guests 649; Exhibitors 554; Woman's Auxiliary members 232 and Medical Assistants Society members 401. The General Assembly type of program with discussion conference was continued as in previous years and the 102 technical exhibits received the usual generous attention of the registrants.

ORGANIZATIONAL ACTIVITIES

MICHIGAN CLINICAL INSTITUTE

The Tenth Michigan Clinical Institute was held in Detroit, March 7-8-9, 1956. Total registration was 2,475 and the Operating Room Nurses Conference was held in conjunction with this year's M.C.I. as well as a special conference for Residents, Interns and Senior Medical Students. Nine members of the Michigan State Medical Society who were Presidents of national medical organizations received special awards at a luncheon held in their honor.

ANNUAL SECRETARIES-PUBLIC RELATIONS CONFERENCE

In 1956 the three-day County Secretaries-Public Relations Seminar was inaugurated and was held January 27-28-29. The program was so successful that the participants voted overwhelmingly to continue the three-day format next year.

*The detailed Membership Record by counties will be published in the April number.

SECRETARY'S LETTERS

As part of the Society's general educational and informational program for individual members and for component County Societies there were issued during the year 1956 eight Secretary's Letters (three to all members and five to County Secretaries and keymen). These informational bulletins were in addition to the monthly issues of THE JOURNAL with its scientific articles and informative news items. In addition, eight Legislative Bulletins were issued to keymen during the 1956 Legislative Session to keep the membership informed of activities in the State Legislature pertaining to the practice of medicine.

COMMITTEES

Time and space do not permit the listing in detail of the many activities of all the committees contributing to the many splendid programs of the State Society. The accomplishments of the committees of the Society were achieved at the expense of many hours of personal sacrifice on the part of the personnel of the various committees. During 1956, eighty-one meetings were held by the forty-eight committees of the Michigan State Medical Society. Practically every meeting was attended by your Executive Director or Secretary. A total of 527 members of your State Medical Society gave freely of their time to attend these meetings and assist in the operational activities of the State Society. Too much commendation cannot be accorded the committee members who contributed their time and effort to develop and execute constructive programs—both scientific and economic—for the public welfare and to maintain the position of leadership enjoyed by the Michigan State Medical Society in the field of progressive medical planning.

FINANCES

An audit of the books of the Society was completed by Knostman & Smith as of December 24, 1956. This has been submitted to the Finance Committee for study and is available to any member of the Society for perusal at the Executive office, 606 Townsend St., Lansing, Michigan. A brief summary of the audit produces the following information:

Assets:

Cash	$ 29,813.31
Accounts Receivable	23,977.95
Investments	229,795.25
Property & Equipment	53,279.20
Other Assets	231.66
Total Assets	$337,097.37
Liabilities:	
Accounts Payable	$ 16,292.44
Deferred Income	15,810.00
Total Liabilities	$ 32,102.44
Society Equities	
Reserved for Special Purposes	
Public Education Reserve	$ 57,245.00
Public Education Program	73,891.87
Public Service Account	3,675.16
Professional Relations Account	4,897.50
Rheumatic Fever Control Program	7,675.56
Contingent Fund	53,614.34
Building Maintenance	14,124.94
General Society Equity	89,870.56
Total Liabilities & Equities	$337,097.37

It is noted from the Income and Expense summary of the period December 24, 1955, to December 24, 1956, that the total income for the period was $440,607.90 less expenses of $400,547.59 producing a net gain for the year of $40,060.31 with a balance on hand December 24, 1956, of $304,994.93.

THE JOURNAL

The following financial information relative to THE JOURNAL is found in the annual audit report of Knostman & Smith.

Income was $94,400.27 which is $10,500.27 over the tentative budget for 1956. Expenses were $93,303.57 which was $9,403.57 over the 1956 estimated budget. However, this figure indicates a net gain for the year 1956 of $1,096.70.

Included in the total income of $94,400.27 was only $8,173.49 received from the allocation of membership dues.

During 1956, the cover illustrations continued to be done by Mr. Dirk Gringhuis and graphically depicted various activities of the MSMS.

1956 HOUSE OF DELEGATES

The 91st Annual Session of the Michigan State Medical Society's House of Delegates was held in Detroit, September 24-25, 1956.

The House of Delegates:

1. Adopted with thanks the President's Address, the President-Elect's Address, the report of Delegates to the American Medical Association, the Annual Report of the President of Woman's Auxiliary to Michigan State Medical Society, and the Annual Report of the President of Michigan State Medical Assistants Society.

2. The Annual Reports of The Council (including the Annual Reports of Committees of The Council) were adopted as amended.

3. Adopted Annual Reports of all Standing Committees and of all Special Committees of the Society; also the report of the House of Delegates' Committee to Study MSMS Financial Structure.

4. Elected Ralph G. Cook, M.D., Kalamazoo, and J. H. Sherk, M.D., Midland (posthumously), as Michigan's Foremost Family Physicians for 1956.

5. Took action on proposed amendments to Constitution and By-Laws, as follows: (a) By-Laws, Chapter 8, Section 10-g—procedure in case of vacancy on Council—approved as amended; (b) By-Laws, Chapter 2, Section 2—re membership in county of practice—disapproved; (c) Constitution, Article X, Sections 1-2-3—to make Vice Speaker a voting member of The Council and of its Executive Committee—to 1957 House of Delegates; (d) By-Laws, Chapter 8, Section 10-j (13)—changing name of a House of Delegates Reference Committee (National Defense and Disaster Planning)—approved.

6. *Adopted resolutions concerning:* (a) Deferring Action re Discipline of Members; (b) Continuation of Councilor Conferences; (c) Establishment of Departments of General Practice in Medical Schools; (d) Committee to Study Use of Word "Clinic"; (e) Equal Health Opportunities for All; (f) Permanent Advisory Committee on Fees (as amended); (g) Practice of Psychiatry is Practice of Medicine; (h) Honorary Membership to J. Joseph Herbert and Dean Gordon H. Scott; (i) Expansion of Medical School Facilities at Wayne State University; (j) Regulation of Ambulance Operation approved and referred to Committee on Traffic Safety; (k) Adequate Funds to carry out Civil Defense (as amended); (l) Medical Classes at Medical Schools to send Representatives to House of Delegates Sessions (as amended); (m) MSMS representatives on Committee Drafting Uniform Autopsy Code (as amended); (n) Esteem of House of Delegates for J. Joseph Herbert; (o) Appreciation of Henry A. Luce, M.D.; (p) New MSMS Headquarters; (q) Appreciation to H. V. Higley, Veterans Administration Administrator; (r) Committee to Study excess beds in Tuberculosis Sanatoriums.

7. *Adopted substitute resolutions concerning:* (a) Michigan Medical Service Annual Report to MSMS House of Delegates; (b) Comprehensive Prepaid Medi-

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ORGANIZATIONAL ACTIVITIES

MICHIGAN CLINICAL INSTITUTE

The Tenth Michigan Clinical Institute was held in Detroit, March 7-8-9, 1956. Total registration was 2,475 and the Operating Room Nurses Conference was held in conjunction with this year's M.C.I. as well as a special conference for Residents, Interns and Senior Medical Students. Nine members of the Michigan State Medical Society who were Presidents of national medical organizations received special awards at a luncheon held in their honor.

ANNUAL SECRETARIES-PUBLIC RELATIONS CONFERENCE

In 1956 the three-day County Secretaries-Public Relations Seminar was inaugurated and was held January 27-28-29. The program was so successful that the participants voted overwhelmingly to continue the three-day format next year.

*The detailed Membership Record by counties will be published in the April number.

SECRETARY'S LETTERS

As part of the Society's general educational and informational program for individual members and for component County Societies there were issued during the year 1956 eight Secretary's Letters (three to all members and five to County Secretaries and keymen). These informational bulletins were in addition to the monthly issues of THE JOURNAL with its scientific articles and informative news items. In addition, eight Legislative Bulletins were issued to keymen during the 1956 Legislative Session to keep the membership informed of activities in the State Legislature pertaining to the practice of medicine.

COMMITTEES

Time and space do not permit the listing in detail of the many activities of all the committees contributing to the many splendid programs of the State Society. The accomplishments of the committees of the Society were achieved at the expense of many hours of personal sacrifice on the part of the personnel of the various committees. During 1956, eighty-one meetings were held by the forty-eight committees of the Michigan State Medical Society. Practically every meeting was attended by your Executive Director or Secretary. A total of 527 members of your State Medical Society gave freely of their time to attend these meetings and assist in the operational activities of the State Society. Too much commendation cannot be accorded the committee members who contributed their time and effort to develop and execute constructive programs—both scientific and economic—for the public welfare and to maintain the position of leadership enjoyed by the Michigan State Medical Society in the field of progressive medical planning.

FINANCES

An audit of the books of the Society was completed by Knostman & Smith as of December 24, 1956. This has been submitted to the Finance Committee for study and is available to any member of the Society for perusal at the Executive office, 606 Townsend St., Lansing, Michigan. A brief summary of the audit produces the following information:

Assets:

Cash	$ 29,813.31
Accounts Receivable	23,977.95
Investments	229,795.25
Property & Equipment	53,279.20
Other Assets	231.66
Total Assets	$337,097.37
Liabilities:	
Accounts Payable	$ 16,292.44
Deferred Income	15,810.00
Total Liabilities	$ 32,102.44
Society Equities	
Reserved for Special Purposes	
Public Education Reserve	$ 57,245.00
Public Education Program	73,891.87
Public Service Account	3,675.16
Professional Relations Account	4,897.50
Rheumatic Fever Control Program	7,675.56
Contingent Fund	53,614.34
Building Maintenance	14,124.94
General Society Equity	89,870.56
Total Liabilities & Equities	$337,097.37

It is noted from the Income and Expense summary of the period December 24, 1955, to December 24, 1956, that the total income for the period was $440,607.90 less expenses of $400,547.59 producing a net gain for the year of $40,060.31 with a balance on hand December 24, 1956, of $304,994.93.

THE JOURNAL

The following financial information relative to THE JOURNAL is found in the annual audit report of Knostman & Smith.

Income was $94,400.27 which is $10,500.27 over the tentative budget for 1956. Expenses were $93,303.57 which was $9,403.57 over the 1956 estimated budget. However, this figure indicates a net gain for the year 1956 of $1,096.70.

Included in the total income of $94,400.27 was only $8,173.49 received from the allocation of membership dues.

During 1956, the cover illustrations continued to be done by Mr. Dirk Gringhuis and graphically depicted various activities of the MSMS.

1956 HOUSE OF DELEGATES

The 91st Annual Session of the Michigan State Medical Society's House of Delegates was held in Detroit, September 24-25, 1956.

The House of Delegates:

1. Adopted with thanks the President's Address, the President-Elect's Address, the report of Delegates to the American Medical Association, the Annual Report of the President of Woman's Auxiliary to Michigan State Medical Society, and the Annual Report of the President of Michigan State Medical Assistants Society.

2. The Annual Reports of The Council (including the Annual Reports of Committees of The Council) were adopted as amended.

3. Adopted Annual Reports of all Standing Committees and of all Special Committees of the Society; also the report of the House of Delegates' Committee to Study MSMS Financial Structure.

4. Elected Ralph G. Cook, M.D., Kalamazoo, and J. H. Sherk, M.D., Midland (posthumously), as Michigan's Foremost Family Physicians for 1956.

5. Took action on proposed amendments to Constitution and By-Laws, as follows: (a) By-Laws, Chapter 8, Section 10-g—procedure in case of vacancy on Council—approved as amended; (b) By-Laws, Chapter 2, Section 2—re membership in county of practice—disapproved; (c) Constitution, Article X, Sections 1-2-3—to make Vice Speaker a voting member of The Council and of its Executive Committee—to 1957 House of Delegates; (d) By-Laws, Chapter 8, Section 10-j (13)—changing name of a House of Delegates Reference Committee (National Defense and Disaster Planning)—approved.

6. *Adopted resolutions concerning:* (a) Deferring Action re Discipline of Members; (b) Continuation of Councilor Conferences; (c) Establishment of Departments of General Practice in Medical Schools; (d) Committee to Study Use of Word "Clinic"; (e) Equal Health Opportunities for All; (f) Permanent Advisory Committee on Fees (as amended); (g) Practice of Psychiatry is Practice of Medicine; (h) Honorary Membership to J. Joseph Herbert and Dean Gordon H. Scott; (i) Expansion of Medical School Facilities at Wayne State University; (j) Regulation of Ambulance Operation approved and referred to Committee on Traffic Safety; (k) Adequate Funds to carry out Civil Defense (as amended); (l) Medical Classes at Medical Schools to send Representatives to House of Delegates Sessions (as amended); (m) MSMS representatives on Committee Drafting Uniform Autopsy Code (as amended); (n) Esteem of House of Delegates for J. Joseph Herbert; (o) Appreciation of Henry A. Luce, M.D.; (p) New MSMS Headquarters; (q) Appreciation to H. V. Higley, Veterans Administration Administrator; (r) Committee to Study excess beds in Tuberculosis Sanatoriums.

7. *Adopted substitute resolutions concerning:* (a) Michigan Medical Service Annual Report to MSMS House of Delegates; (b) Comprehensive Prepaid Medi-

cal Care Insurance Plans and Blue Shield Plans for Diagnostic Out-Patient Services; (c) (Urging Total Participation of M.D.'s in Michigan Medical Service (two resolutions); (d) Plan for Expediting Work of House of Delegates.

8. *Tabled Motion* re Information from AMA Delegates.

9. *Deferred Resolutions re:* (a) Postgraduate Education of Other Healing Arts; (b) MSMS Attitude re Other Healing Arts; (c) Approval of Mediation-Ethics-Grievance Committee's Recommendations.

10. *Disapproved Resolutions concerning:* (a) Council Minutes to all MSMS Delegates; (b) Annual Registration of M.D.'s (c) Submission of House of Delegates Resolutions in Advance; (d) Report Within Seven Days of House of Delegates Proceedings; (e) State and County Prerogatives in Discipline of Members; (f) MSMS Approval of County Society Constitution and By-Laws Revisions.

11. *Elected to Special Memberships:*
(a) Thirty-one members to Life Membership: (Berrien County) Clarence Gillette, M.D.; (Genesee County) Henry Cook, M.D.; (Ionia County) J. W. C. Fleming, M.D.; (Kalamazoo County) U. Sherman Gregg, M.D.; (Marquette County) Celestin LeGolvan, M.D., and George M. Waldie, M.D.; (Muskegon County) Harry L. Clark, M.D., Marie Keilin, M.D., and Eugene S. Thornton, M.D.; (Oakland County) George L. Hagman, M.D., and John K. Ormond, M.D.; (Wayne County) Stilson R. Ashe, M.D., William N. Braley, M.D., Fritz W. Bramigk, M.D., Bruno B. Brunke, M.D., Peter H. Darpin, M.D., Henri L. Gratton, M.D., Sarkis K. Keshishian, M.D., John C. Koch, M.D., Alfred D. LaFerte, M.D., Wm. W. MacGregor, M.D., Emil V. Mayer, M.D., Wm. R. McClure, M.D., Cary P. McCord, M.D., Wm. E. Miller, M.D., Grover C. Penberthy, M.D., Lyman J. Pinney, M.D., Ralph W. Ridge, M.D., Paul C. Rhode, M.D., Jacob M. Sutherland, M.D., and Elmer L. Whitney, M.D.
(b) Nine members to Retired Membership: (Calhoun) A. D. Sharp, M.D.; (Saginaw County) Lloyd A. Campbell, M.D.; (Wayne County) Ladislaus Bogusz, M.D.; Clyde H. Chase, M.D., James C. Danforth, Sr., M.D.; Frank MacKenzie, M.D., William D. Ryan, M.D., Clarence E. Weaver, M.D., and Wirt A. Dawson, M.D.
(c) Fifty-nine M.D.'s to Associate Membership: (Marquette-Alger County) Sara Schweinsberg, M.D.; (Muskegon County) Mary Ellen Hennessey, M.D.; (Washtenaw County) Malcolm A. Bagshaw, M.D., Joseph B. Boulos, M.D., Gerald L. Brody, M.D., Joseph H. Chandler, M.D., Norman E. Clarke, Jr., M.D., Mark A. Everett, M.D., Norman A. Fox, Jr., M.D., Robert L. Gillett, M.D., Glen G. Golloway, M.D., Jack E. Goodwin, M.D., John T. Hayes, M.D., Erwin P. Hoffman, M.D., Clifford L. House, M.D., Edwin M. Hubbard, M.D., A. Hartwell Jewell, Jr., M.D., J. A. Arthur Lavigne, M.D., George E. Lewis, Jr., M.D., John D. Lynch, M.D., James W. Mackenzie, M.D., Henry E. Malcolm, M.D., Rolf F. Miller, M.D., Robert F. Muller, M.D., Paul Natvig, M.D., Rudolf E. Nobel, M.D., Leon D. Ostrander, Jr., M.D., Warren H. Pearse, M.D., Chrisostomo C. Santos, M.D., Harry J. Schmidt, M.D., Russell Scott, Jr., M.D., Irving Shapiro, M.D., Edwin M. Smith, M.D., Philip R. Steinmetz, M.D., John P. Stewart, M.D., George R. Thompson, M.D., Frederik S. Van Reesema, M.D., Peter D. Vreede, M.D., Donald J. Holmes, M.D., Prasana K. Pati, M.D., John B. Tisserand, M.D., William S. Wilson, M.D., and James A. Wood, M.D.; (Wayne County) Oscar L. Barland, M.D., Robert Borchak, M.D., Richard A. Bruehl, M.D., John P. Connolly, M.D., Douglas R. Coyne, M.D., Leonard Fox, M.D., Maurice J. Hauser, M.D., Loyal W. Jodar, M.D., Benjamin Mihay, M.D., John H. Schlemer, M.D., Fredrick L. Sperry, M.D., Bela J. Szappanyos, M.D., Jerome S. Weingarten, M.D., Frank A. Weiser, M.D., Joseph Weiss, M.D., and Charles R. Williams, M.D.

12. *Elected the following officers:*
(a) A. E. Schiller, M.D., Detroit, as Councilor of the 1st District (1961).
(b) H. J. Meier, M.D., Coldwater, as Councilor of the 3rd District (1961).
(c) Ralph W. Shook, M.D., Kalamazoo, as Councilor of the 4th District (1961).
(d) C. Allen Payne, M.D., Grand Rapids, as Councilor of the 5th District (1961).
(e) H. H. Hiscock, M.D., Flint, as Councilor of the 6th District (1961).
(f) W. D. Barrett, M.D., Detroit (1958); W. H. Huron, M.D., Iron Mountain (1958); and R. L. Novy, M.D., Detroit (1958), as Delegates to the American Medical Association.
(g) Wm. Bromme, M.D., Detroit (1958); J. R. Rodger, M.D., Bellaire (1958); and G. W. Slagle, M.D., Battle Creek (1958), as Alternate Delegates to the American Medical Association.
(h) G. W. Slagle, M.D., Battle Creek, as President-Elect.
(i) K. H. Johnson, M.D., Lansing, as Speaker, House of Delegates.
(j) J. J. Lightbody, M.D., Detroit, as Vice Speaker, House of Delegates.

OTHER ORGANIZATIONAL ACTIVITIES

1. The Residents-Internes-Senior Medical Students Conference was held in Detroit, March 7, 1956. The MSMS again financially sponsored sending Delegates from Michigan's two Medical Schools to the Student AMA Convention in Chicago May 1956.

2. Semi-anuual meetings of the seven MSMS delegates to the AMA and the alternate delegates were held as usual.

3. Modern membership recording was instituted during the year to facilitate the MSMS records and billing. This was done by utilizing IBM equipment. The results of this have already justified the judgment of The Council in installing this method. For instance, in January 1956, a total of 231 members paid dues, totaling $12,690.00; to January 21, 1957, a total of 1,737 paid dues, totaling $98,185.00.

4. Councilor District meetings were held throughout the state as an innovation in better informing the members of the MSMS House of Delegates in matters to be considered at the annual meeting in September.

MICHIGAN MEDICAL SERVICE

This organization continues to be a major activity of the MSMS. During the year several additional MSMS members were added to the Board of Directors. Of the officer personel your secretary became President, MSMS President Arch Walls was chosen Vice-President, Editor Wilfrid Haughey became Chairman of the Board and Councilor Harris succeeded the late Robert H. Baker, M.D., as secretary.

Appreciation of the need for changes in the MMS contracts and benefits is evidenced by the fact that three committees of Doctors of Medicine, one from the House of Delegates, one from the MSMS and one from MMS are now studying changes to meet the various demands, better service to the public and services consistent with constant economic changes. These studies will be made with the greatest possible realism and with constant attention to actuarial soundness.

Women's Auxuliary.—The Auxiliary continued its many projects and had a very successful and active year.

Medical Assistants Society.—This group continued its activities and expanded its organization in The Upper

Peninsula. Michigan Delegates and members of the Advisory Committee played an important part in the development of a National Organization at a meeting held in Milwaukee.

Contacts with Governmental and Voluntary agencies have been maintained effectively during the year.

BEAUMONT MEMORIAL RESTORATION

The Beaumont Committee, under the chairmanship of Otto O. Beck, M.D., has actively pursued its activities. A drive for additional funds to liquidate the $9,000.00 deficit was successful in raising over $7,600.00.

PUBLIC RELATIONS

Serious attempts to influence public opinion against voluntary health insurance were made during the past twelve months. This naturally affected doctors of medicine both directly and indirectly.

Certainly, this is no news to you and perhaps does not belong in the Secretary's report on MSMS public relations activities. But I think it will serve as a contrasting background for the following outline of positive public relations endeavor.

It would seem that the medical profession could now say that it is "Winning Friends for Medicine." And the MSMS PR guidebook is still the "bible" for county medical societies in developing their increasingly efficient public relations programs.

Sparking this job of carrying the PR message were MSMS officers and Councilors as well as C. Allen Payne, M.D., Immediate Past Chairman of the PR Committee, PR Counsel H. W. Brenneman and the public relations field secretaries. Special recognition should go to William S. Jones, M.D., for his contribution to good relations by attending a meeting of nearly every component county society. As you realize, this entailed literally thousands of miles of travel and innumerable days away from his busy practice.

In September, following Doctor Payne's election as Councilor, R. Wallace Teed, M.D., was appointed Chairman of the MSMS PR Committee, succeeding Doctor Payne.

Press relations, despite the attack previously mentioned, improved a good deal in 1956, due principally to the forthrightness which MSMS exhibited in its contact with writers and editors.

Figures or statistics on the amount of newspaper coverage devoted to medicine and M.D.'s are sometimes meaningless unless they can be related in more understandable terms. For example, the most recent press release prepared by our staff was reprinted in 101 Michigan newspapers. The item was the MSMS immunization campaign, "Operation Armor." Similar coverage was accorded releases on other MSMS programs and activities, such as Traffic Safety, Annual Session, Awards, and so on.

Television programming supplied by MSMS during 1956 amounted to just under forty-five hours on both Detroit and outstate stations. Total running time of motion pictures furnished by MSMS to civic groups, TV stations amounted to over 150 hours. Radio received special attention in 1956 and in addition to the 448 hours of radio programming supplied by MSMS, special news releases and tape recordings were sent periodically to all Michigan stations. The final bright spot in the communications picture is the outstanding coverage accorded our 1956 Annual Session by *all* media.

A new project and service is currently under development in our Public Relations Office. This is the PR Library, being set up by a qualified librarian so that the information it contains can be put to maximum use by MSMS members and other interested groups. Ours is the first state medical society to organize a library that is specifically adapted to existing and future medical PR needs. The secretary who will serve as part-time librarian, will be responsible for filling loan requests for reference material in scientific and socio-economic areas as well as for motion pictures, radio tapes, scripts and other material too numerous to mention.

Hardly a year goes by that Michigan's PR effort is not cited for excellence. The year 1956 was no exception for our state-wide campaign during Medical Education Week received national attention and our program outline and scrapbook was reproduced for distribution to PR departments of the nation's eighty-one medical schools.

I should like, at this point, to forego the detailing of our comprehensive PR program, other than to mention the broader spheres of activity. These include: pamphlet production and distribution, exhibits, general society liaison and committee service, attendance at state and national meetings by Society Officers and PR staff, annual awards, legislative activity, motion picture production.

The past PR effort is important only in relation to the future and, gentlemen, our future for 1957 is already overcast with storm clouds. The forecast is not all gloom and doom, but a storm is most certainly coming and our ability to weather it will depend in large measure on the success of our individual and collective relations with the public. We believe that 1957 will be a year of decision for the voluntary health insurance plans and thus, inescapably, it will be a year of decision for the medical profession. We shall need every ounce of good will that we can garner. We shall need public understanding. We shall need press understanding and support. We shall need to make progress in becoming the recognized *leaders* in the field of health care and perhaps this could best be done by willingly accepting the challenges of tomorrow that are already apparent.

These things must be done this year, soon, now—before it is too late—or we shall fail.

LEGISLATION

The 1956 sessions of the Michigan Legislature and the national Congress have been duly recorded in the mid-summer report of The Council. No elaboration is needed here. However, since both of these legislative bodies are now preparing to embark on a new year's deliberation, this is a propitious time to look ahead to the tasks confronting Michigan Doctors of Medicine in the legislative and political fields.

The Legislative Committee of MSMS, in meeting January 10, apprised us that we may expect the introduction of approximately eighty legislative proposals in Lansing affecting the field of health; many will be revivals of proposals previously defeated in the House and Senate, while some will be the products of the changing times, such as those in the realms of atomic energy, automation and specialization. More concise information will be forthcoming from the MSMS executive office as the legislation appears in fact.

Noteworthy, though, is the progress being made by a liaison committee between the MSMS and the Michigan Osteopathic Association toward better agreement between the two professional groups, in contrast to past legislative differences.

There is one fact that becomes more evident each year. The impact of legislative activity and political action upon the medical profession is powerful, and vice versa. At no time in history has it been more patent that the individual M.D. has a stake, a place and a responsibility in the political sphere. The doctor is a man of his community, and the obligations of his oath to provide the best health care to his patient go beyond his office door into the legislative halls in Lansing and Washington. This is the age of socio-

economic change in the practice of medicine as well as scientific progress in the art of healing.

THE EXECUTIVE OFFICE AND PERSONNEL

Various improvements have been made in the Executive Offices. Increased parking facilities have been provided. A library has been established in the basement to house various reference records, recordings, legal opinions and publications.

During 1956, the MSMS suffered a loss in the death of its Legal Counsel, J. Joseph Herbert. This position was filled by securing the services of Mr. Lester Dodd of Detroit. Mr. Dodd is a past president of the Michigan State Bar.

During the year, Assistant Public Relations Counsel, DeWitt Brewer, resigned and was replaced by Warren Tryloff, Field Secretary in the Detroit office. He, in turn, was replaced by Jack Pardee as Field Secretary for the Detroit area. Several additions and replacements were made in the stenographic pool, and Miss Vada Studt was transferred from the pool to the third floor where she becomes an Assistant Secretary in the Public Relations Department and assumes the new duties of Librarian.

The stenographic pool is still operating shorthanded and there is an urgent increasing need for an assistant bookkeeper to relieve Mr. Roney of some of his activities which now include all the bookkeeping, membership records and JOURNAL advertising activities.

During the year, a committee was appointed to take a "Big Look" at the general organizational set-up and physical plant of the Society. This committee has already recommended some changes in titles of our MSMS office personnel.

Elsewhere on the agenda of this meeting, pursuant to your instructions, your Secretary is making suggestions regarding changes in the MSMS job classification and salary schedule.

The need for increasing office personnel is indicated in the ever-increasing office detail as illustrated in the following figures:

In 1956, the Addressograph ran	386,000	pieces
In 1956, the Meter Machine ran	215,022	pieces
Total	601,022	pieces
Averages	7,700	pieces a week
	1,540	pieces a day

THE COUNCIL

Two new Councilors were elected by the 1956 House of Delegates.

C. Allen Payne, M.D., Grand Rapids, succeeded J. D. Miller, M.D., in the 5th District.

Harold J. Meier, M.D., Coldwater, succeeded George W. Slagle, M.D., in the 3rd District.

HIGHLIGHTS IN PROGRESS DURING 1956

1. New Councilor Conferences were held in every District between July 23 and September 23 to outline socio-economic progress to MSMS Delegates, Alternate Delegates and County Society Officers.

2. "Medicare" was inaugurated during the past year (U. S. Public Law 539) to provide medical and surgical care for servicemen's dependents. The contract for Michigan was negotiated October 24, in Washington, D. C. Michigan Medical Service was appointed agent of MSMS in this new program.

3. The Governor's Public Health Study Commission was supplied with a statement outlining the position of the Michigan State Medical Society on various public health measures. The outline was presented by MSMS President Arch Walls, M.D.

4. The Governor's Study Commission on Prepaid Hospital Care Plans requested MSMS to name a consultant to work with the Commission in undertaking this study. Secretary Foster was appointed. (The study was held in abeyance pending selection of a director and obtaining of adequate funds.)

5. A Liaison Committee with the Michigan State Board of Registration in Medicine was appointed. The Council, and subsequently the House of Delegates, adopted resolutions recommending that the Legislature make the office of Executive Secretary of the State Board a full-time position, with adequate remuneration.

6. Adoption of National Board Examinations in Michigan was discussed at a joint meeting with representatives of the two medical schools in this State and the State Board of Registration.

7. The Veterans Administration "home-town medical care program" was continued in Michigan, after MSMS protest against its discontinuance scheduled for July 1, 1957. This insures a continuation of *good medical care* to the veteran, rendered in *his home community.*

8. The Council, and subsequently the House of Delegates, adopted resolutions urging increase in the teaching personnel of Wayne State University College of Medicine, to permit addition of fifty more first-year students annually. Necessary funds to cover this needed increase have been requested of the 1957 Legislature by WSU.

9. Establishment of full-time chairs of preventive medicine and public health at each of the two medical schools in Michigan was endorsed by MSMS—provided such chairs are filled by Doctors of Medicine.

10. The MSMS Medical Advisory Committee to Michigan Hospital Service was reactivated in August at the specific invitation of MMS President John W. Paynter.

11. Michigan Week was endorsed and all MSMS members were urged to actively cooperate in reminding patients that Michigan is a good state to live in. MSMS Executive Director Wm. J. Burns was a member of the Board of Michigan Week.

12. President Arch Walls, M.D., was authorized to appoint an MSMS Committee to meet with officers of the UAW-CIO to discuss medical matters. Committee was appointed and several meetings have been held.

13. The Council and the House of Delegates authorized the selection of a new site and the erection of a new MSMS headquarters building, to adequately house the growing facilities of the Society. Several meetings of the planning committee have been held.

14. The generosity of the membership is best indicated by recent contributions to the Beaumont Memorial Restoration: in less than two months, up to January 23, a total of $7,652.50 was received against the $9,000 indebtedness.

15. Two important committees were appointed during the past year, one to study care of the mentally disturbed in order to obviate long-time hospitalization; the other a Committee on Healing Arts Study.

16. A Gold Medal Award for scientific achievement in this state was created by MSMS during the past year.

17. To service physicians covered by the MSMS health and accident insurance program, Richard M. McDermott was appointed as full-time Michigan representative by the Provident Life and Accident Insurance Company.

18. IBM Equipment was installed by MSMS in 1956 to expedite the handling of MSMS records, beginning January 1, 1957 and to aid the busy doctor with this annual bit of detail.

19. "So You've Been Elected," an organizational handbook for county society officers was developed by MSMS and distributed at the County Secretaries-Public Relations Seminary of January 29, 1956.

The County Secretaries one-day Conference was broadened into a three-day Seminar in 1956, with further up-to-date information to county society officers on socio-economic problems.

20. "Progress"—Because Doctors Work Together" was another informative brochure printed by MSMS during the past year which outlined MSMS services, scientific work, socio-economic activities and its growing scope of interest in the Michigan scene.

RECOMMENDATIONS

After a careful consideration of the continued successful operation of the MSMS and its many projects, I respectfully submit the following recommendations:

1. That MSMS inaugurate necessary surveys on strictly economic and sociologic phases of medical practice, to ascertain where the medical profession is and where it is going in the next ten years in incomes and economic status. According to the Medical Economic survey, Michigan physicians enjoy the greatest incomes (both for general practitioners and for specialist) among all the states in the Union. MSMS should continue to insure such a happy condition for its members. However, very few M.D.'s get much information on economic matters—other than those who attend the Annual County Secretaries Seminar. Hence the above recommendation.

2. That studies be inaugurated concerning the relationships and responsibilities between county medical societies and hospitals in the separate communities.

This would show the position of greater and greater importance to the medical practitioner now assumed by the hospital staff—to the detriment of the county medical society. It will also indicate the proper spheres of influence which rightfully belongs to the M.D. in hospital administration.

3. That a medical coordinator be employed for all scientific activities of the MSMS, both in Postgraduate and Preventive medicine fields.

This man would be a successor to Dr. DeVel, with his duties enlarged. One advantage of this action would be that MSMS might receive more grants from fund raising organizations—such as it now receives for the rheumatic fever activity from the Michigan Heart Association.

4. That the audit date of MSMS books be changed to November 30, to achieve reports to all members of The Council weeks in advance of the annual meeting of The Council.

5. That the MSMS employ a bookeeper with the title of Assistant Secretary and that such an employe be assigned exclusively to Mr. Roney's department—dealing with bookkeeping, membership and JOURNAL advertising.

6. That, subject to approval by component societies, that MSMS assume responsibility for the mailing of follow-up letters (no less than three) to those members in arrears after April 1 of each official year, in order to bring to a minimum the number of members who are subject to suspension according to MSMS By-Laws, Chapter XV, Section 2.

7. That consideration be given to the ground breaking of the new MSMS headquarters in the year 1957 so that the building may be available for use in late 1958.

Some $150,000.00 could be available by 1958 and balance could be financed through a bank and paid off in some two to four years, depending upon the cost of the building. Meanwhile, the Executive Offices could be efficiently run in a larger and modern building and the prestige of the Society would go up with the public as well as with the medical profession.

Your Secretary is grateful for the helpful cooperation given him by this Council during the past year.

Too much commendation cannot be accorded the Executive Office staff for their untiring efforts and loyalty to the MSMS.

Your Secretary is especially appreciative of the constructive advice and services accorded him by Wm. J. Burns, Executive Director, Mr. Dodd, Legal Counsel, Hugh Brenneman, Public Relations Counsel and his staff, Wilfrid Haughey, M.D., Editor, and Robert Roney, Assistant Executive Director. Our field secretaries did an unusual job in their legislative activities.

To everyone who has aided so generously and willingly in the discharge of his duties, your Secretary is most grateful.

Respectfully Submitted
L. FERNALD FOSTER, M.D.
Secretary

TREASURER'S ANNUAL REPORT—1956

(January 1 to December 24, 1956)

Mr. Chairman and members of the Council
of the Michigan State Medical Society:

I herewith submit a report of the securities and cash belonging to the Michigan State Medical Society in my possession as duly elected Treasurer for the year January 1956 to January 1957.

The appended list of bonds and time certificates totaling $92,000 face value are in lock box C131 Michigan National Bank Trust Department in Grand Rapids.

Balance on hand as of January 1, 1956	$6,368.01
Interest received from bonds and certificates of deposit—January 1, 1956, to January 1, 1957	$2,345.00
Balance on hand as of December 31, 1956	$8,713.01

Respectfully submitted,
WILLIAM A. HYLAND, M.D.
Treasurer

MICHIGAN STATE MEDICAL SOCIETY SECURITIES

3 Michigan National Bank Savings Certificates @ $5,000 ea.	$15,000
1 Michigan National Bank Savings Certificate	25,000
7 United States Savings Bonds, Series G @ $5,000 ea.	35,000
5 United States Savings Bonds, Series G @ $1,000 ea.	5,000
4 United States Savings Bonds, Series K @ $1,000 ea.	4,000
8 United States Government Notes 75-80 @ $1,000 ea.	8,000
Total	$92,000

Also in Lock Box C131 are the following safe-keeping receipts covering government bonds in the name of the Society:

Michigan National Bank, Grand Rapids—Receipt #4378 dated April 27, 1956 (These securities are held for us in the vaults of the First National Bank of Chicago under their receipt #108665)	$25,000
Michigan National Bank, Lansing—Receipt #A718 dated January 11, 1956	45,000
Michigan National Bank, Lansing—Receipt #A726 dated February 16, 1955	10,000
Michigan National Bank, Lansing—Receipt #A864 dated March 1, 1956	25,000
Michigan National Bank, Grand Rapids—Receipt #4536 dated August 29, 1956	35,000
Total	$140,000

TOTAL DEPOSITS MADE INTO THE TREASURER'S COMMERCIAL ACCOUNT DURING 1956

February 1, 1956	$ 375.00
March 5, 1956	62.50
April 30, 1956	297.50
May 1, 1956	62.50
August 14, 1956	375.00
September 21, 1956	250.00
October 26, 1956	110.00
November 1, 1956	62.50
November 16, 1956	437.50
November 21, 1956	312.50
Total	$2,345.00

EDITOR'S ANNUAL REPORT—1956

THE JOURNAL of the MICHIGAN STATE MEDICAL SOCIETY has now completed fifty-five years of publication. You may remember it was established by Andrew P. Biddle, M.D., Secretary of the Society, to replace the annually published "Transactions." The Society had just been thoroughly reorganized into a democratic body with members, branches (County Medical Societies) and a state organization including, besides the usual officers, a Council (Board of Directors) and a legislative body (House of Delegates) on a basis of one representative for every fifty members or major fraction thereof.

The activities of the Society were being stepped up and an attempt was being made to stimulate the interest of all the doctors in the work of the Society. Previously, there had been only one meeting a year, and very little fraternizing. The Council and the newly appointed Editor established THE JOURNAL as a means of communication among all members at least once a month. The Editor published news, activities and reports, as well as scientific papers, abstracts, and reviews. Pages of THE JOURNAL were set aside and assistant editors appointed to review the latest information on such departments as medicine, surgery, et cetera. THE JOURNAL was immediately successful. The membership in the Society grew. Dr. Biddle was an educator as well as being interested in organizational medical affairs.

Down through the years our editors have carried on in somewhat the same vein. The House of Delegates is the policy-making body, The Council is charged with the financial end but interprets policy in the interim between House of Delegates meetings. The Editor is charged with the interpretation of both bodies, expressing their ideals and theory of organization; publishing for the membership the latest of scientific information, as well as reporting primarily on the economic, socio- and medico-political affairs upon which the very existence of the private practice of medicine depends.

The last fifteen years have been ones of great economic and social importance. Pressure groups, as well as government, have attempted to hamper our traditional and established liberties and privileges. Legislation has been proposed to which the profession has objected, until it became an established idea that the medical profession was opposed to everything. During these years, we have increased the size of THE JOURNAL almost 50 per cent. We have adopted a strong editorial policy of keeping our members aware of policies being offered by our detractors, and socio-economic conditions affecting our very existence.

The editorial and news features of THE JOURNAL have stressed to the readers an awareness to such problems as seemed of most interest, to the extent at times of a possible over-emphasis. The scientific section of THE JOURNAL has always presented as fine and advanced material as the best thinkers in our Society and our invited guests could give. During the year, we had 161 different names signed to our original papers. Eleven of these names appeared twice, making an average of over fourteen authors for each number.

We have prepared and published sixty editorials, forty-seven book reviews, and forty-nine memorial tributes, one to Past-President Robert Baker, and one to our Legal Counsel, J. Joseph Herbert. Nine of our members were honored for having been president of some national medical or hospital organization.

About thriteen years ago, we abandoned the stereotyped cover and began using that page of THE JOURNAL to honor some of our still living Past Presidents and Speakers of the House of Delegates. We then began casting about for specialty interesting items of value to the membership or the Society. During that thirteen years there have not been two covers of THE JOURNAL alike. Early we assigned certain specified numbers to some special interest of the profession. We published the first medical journal devoted to Atomic Medicine. We have stressed many special fields. During the year 1956, we continued to recognize distinct and compelling interests. In most instances, a proportion of the scientific papers appearing in any special number have had a bearing on the cover selected. In fact, the covers in almost every instance have been built about the subject matter.

Our January numbers for several years have been devoted in some special manner to Heart. This year it was "Rheumatic Fever—The Chain Can Be Broken." In February, we honored the University of Michigan Medical School (1850-1956) with sketches of some new buildings. March saluted Wayne State University School of Medicine with some of its most modern new buildings and its history. April, traditionally Cancer month, featured "Education-Research-Service" — "Three Swords Against Cancer." May was dedicated to the Michigan Foundation for Medical and Health Education—stressing rural M.D.'s. June, assigned to Michigan Medical Service for many years, featured the Blue Shield. July announced and published the program for the 91st Annual Session "All Roads Lead to Detroit." August—"Trauma," and as a supplement a directory of our membership, the Auxiliary, and Medical Assistants. September—Ingham County Medical Society and its 28th Annual Clinic Day. October—"Diabetes," featuring and picturing the five great leaders: Aretaeus, Langerhans, Muncowski, Kussmaul and Banting. November—"The Physician Serves His Patient—The Society Serves the Public," a public relations number with reports of the presidents or chairmen of twenty-eight committees, agencies or groups serving the public. December presented the Michigan Clinical Institute program for next March in Detroit.

We are proud of this year's Michigan State Medical Society accomplishments in every field of endeavor, and especially honored to have been active in spreading the record in a permanent form.

This year's Directory was again published in a separate section, but delayed the publication of that number of THE JOURNAL for three weeks. We are hoping that in the year of 1957, we may prepare the Directory and have it all printed except the cover, then make it part II of the number next due. July has been selected as the date of the Directory, but I trust our members will be complacent if we do not delay THE JOURNAL to accommodate some late proof or item.

The Editor wishes to express his unbounded gratitude to his Publication Committee, to all the numerous ones who have had duties in assemblying special number material, and to the Council's each and every member who has made his work so enjoyable.

Again the Editor has found stimulation and enormous satisfaction in our friendly associations.

Respectfully submitted,
WILFRID HAUGHEY, M.D.
Editor

REPORT ON AND EVALUATION OF THE MSMS RHEUMATIC FEVER CONTROL PROGRAM—1956

CHRONOLOGY AND SALIENT FEATURES

April 26, 1945: Preventive Medicine Committee MSMS.—Extract of minutes: "The Preventive Medicine Committee respectfully recommends to the Executive Committee of the Council MSMS that the Chairman of the Child Welfare Committee, the Chairman of the Heart and Degenerative Disease Committee, the Director of the Michigan Crippled Children Commission, together with Secretary Foster confer for the purpose of expanding the program of education, control and care of the rheumatic fever patient and that the Committee's findings be submitted to the Council MSMS."

May 13, 1945: Special Rheumatic Fever Committee.—Extract of the minutes: "A rheumatic fever program should concern itself with (1) Education—lay and professional; (2) Research; (3) Case finding, diagnostic services, treatment and follow-up services and schooling facilities. This program is the combined effort of the Michigan State Medical Society and the Michigan Crippled Children Commission to provide adequate facilities for the finding, treatment and prevention of rheumatic fever. It is designed to keep the activity in the hands of the practicing profession with no disturbance of the established physician—patient relationship."

July 13-14, 1945: The Council MSMS.—The report of the meeting of May 13, 1945 of the Special Rheumatic Fever Committee was presented to the Council. After full discussion motion was made that the report of the Committee be received with thanks and that the Committee be commended for its efforts; carried unanimously.

September 6, 1945: Rheumatic Fever Control Committee.—First meeting of the Committee. Proposed Diagnostic and Consultation Centers: Marquette, Traverse City, Bay City, Grand Rapids, Lansing, Flint, Ann Arbor, Jackson and Kalamazoo.

Fundamental rules for Diagnostic and Consultation Centers:

1. The work shall be limited to diagnostic and consultation service only.
2. All reports and recommendations must go to a private doctor of medicine.
3. Indigents are the responsibility of the Michigan Crippled Children Commission. Private patients must be charged a fee.
4. Reporting shall be made of all cases to the Michigan Department of Health.
5. Uniform blanks shall be used by all Centers. Accurate records shall be kept, together with follow-up reports.
6. Definite follow-ups should be established and be included among the recommendations to the referring doctor of medicine.

January 17, 1946: Michigan Society for Crippled Children and Adults, Inc.—agrees to financial support on a year-to-year basis, beginning with the sum of $15,000.00 for the year 1946.

January 18, 1947: Wayne County Medical Society Rheumatic Fever Control Committee appointed by the Society's President.

April 16, 1947: The Executive Committee of the Council establishes the principle of voluntary participation by County Medical Societies.

July 22, 1948: Medical Coordinator for the MSMS Rheumatic Fever Control Program recommended by the Rheumatic Fever Control Committee and approved by the Council, effective January 1, 1949.

January 5, 1949: Michigan Heart Association incorporated.

June 22, 1949: Michigan Heart Association offers financial support on a year to year basis, beginning with $32,515.72 for the year 1949.

May 10, 1950: Michigan Chapter of the Arthritis and Rheumatism Foundation makes Financial contribution of $2,250.00.

May 2, 1951: Annual Postgraduate Fellowships for the Study of Rheumatic Fever established.

October 31, 1951: Series of "Physician's Desk Reference Cards for Rheumatic Fever begun.

1949-1954: New Rheumatic Fever Diagnostic and Consultation Centers organized: Alpena, Benton Harbor—St. Joseph, Muskegon, Saginaw, Sault Ste Marie, Royal Oak, Petoskey.

January 20, 1954: Health Department Participation in Heart Disease Control.—The Rheumatic Fever Control Committee and the Executive Committee of the Council (May 19, 1954): Approval of the general principles of Health Department participation in heart disease control. . . . Implementation to be framed within the needs and capabilities of each community as determined jointly between the local County Medical Society and the local Health Department, with participation of interested organizations.

September 8, 1954: Liaison with the Special Education Committee of the Michigan Department of Public Instruction established, for a study of the needs of the cardiac and the rheumatic child in school.

February 2, 1955: Penicillin Distribution.—Rheumatic Fever Control Committee and Executive Committee of the Council (February 23, 1955): (1) Statement of policy that the Rheumatic Fever Control Committee is a diagnostic and consultation service and it is not within its province to prescribe or distribute drugs; (2) that prophylaxis of rheumatic fever (recurrences) (by the use of penicillin) for the medical indigent should be handled similar to the present regulation governing distribution of gamma globulin, i.e., the drug used by the physician to be replaced by the local Health Department.

December 7, 1955: Michigan Crippled Children Commission Program of Rheumatic Fever Prophylaxis.—Under this plan the Michigan Crippled Children Commission will undertake to pay the physician—out of Trust Funds administered by the Commission—a standard fee of $3.00 for the monthly administration of penicillin to rheumatic children under age 21 who qualify under the Crippled and/or Afflicted Children's Acts.

January 16, 1956: Distribution of Injectable Penicillin by the Health Department for the prevention of streptococcal infections in persons who have had rheumatic fever or who have rheumatic heart disease, on application by the family physician, and the Rheumatic Fever Prophylaxis Program of the Michigan Crippled Children Commission become effective.

FINANCIAL SUMMARY

Expenditures	
Total expenditures 1945-1956 incl. (12 years)	$205,785.87
Smallest annual expenditure (1945)	520.30
Largest annual expenditure (1952)	26,318.23
Average annual expenditure 12 years	17,788.45
Average annual expenditure last 10 years	20,534.90
Financial Contributions by	
Michigan Society for Crippled Children & Adults	58,140.14
Arthritis & Rheumatism Foundation	4,500.00
Michigan Heart Association	150,821.29

ACHIEVEMENTS IN EDUCATION

Lay Education:

1. Pamphlet entitled: "Rheumatic Fever. Nine Questions and Answers for Parents" prepared by the Rheumatic Fever Control Committee, printed and distributed

by the Michigan Department of Health. Approximately 50,000 copies.

2. Pamphlet entitled: "The Cardiac and the Rheumatic Child in School. Five Questions and Answers for Teachers," prepared jointly by the Rheumatic Fever Control Committee and the Committee on Education of Exceptional Children of the Michigan Department of Public Instruction, printed and published by the Rheumatic Fever Control Committee, distributed by the joint sponsors. 20,000 copies.

3. Numerous (untabulated talks on the subject of rheumatic fever for lay groups, such as Service Clubs, PTA Health Groups, Community Health Councils, and the like.

4. Radio and TV spot announcements in cooperation with the Michigan Heart Association. TV programs and interviews.

5. Liaison with the Committee on Education of Exceptional Children of the Department of Public Instruction.

6. Cooperation with the Michigan Heart Association's Heart Units.

Professional Education:

1. Series of "Physician's Desk Reference Cards for Rheumatic Fever," twenty topics related to the problems of rheumatic fever and rheumatic heart disease, with frequent revisions, prepared by the Rheumatic Fever Control Committee and distributed at intervals to all members of the Michigan State Medical Society.

2. Presentation of one or more scientific programs on rheumatic fever for twenty-seven County Medical Societies.

3. Presentations by outstanding national authorities on rheumatic fever, annually on Heart Day of the Michigan Clinical Institute.

4. Publication of scientific papers on Rheumatic Fever in THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY.

5. Annual Postgraduate Fellowships for the Study of Rheumatic Fever, carrying a stipend of not to exceed $500.00, awarded to date to twenty-three doctors of medicine who meet the Committee's requirements for applicants.

ACHIEVEMENTS IN RESEARCH

By decision of the Rheumatic Fever Control Committee (May 13, 1945), problems of research are to be left to other auspices.

ACHIEVEMENTS IN CASE FINDING

In the matter of case finding, one of the primary objectives of the Rheumatic Fever Control Program (May 13, 1945), the feature undertaking is the organization of the several Rheumatic Fever Diagnostic and Consultation Centers. The basic principles governing this project can be summarized as follows:

1. Rheumatic Fever Diagnostic and Consultation Centers shall be organized, controlled and operated by the local County Medical Society in cooperation with the MSMS Rheumatic Fever Control Committee.

2. The services rendered shall be consultative and diagnostic exclusively and the Centers shall not undertake treatment.

3. Patients shall be admitted to the Centers on direct referral by a physician exclusively.

4. The Centers shall not be "free" clinics. A standard fee for examination shall be charged. In the case of the medically indigent this charge may be paid by another party.

5. Reports and recommendations shall be forwarded to the referring physician for use at his discretion.

Acceptance.—The principle of Rheumatic Fever Diagnostic and Consultation Centers has been accepted by the County Medical Societies located in the cities listed in paragraph I, of this report. Only 3 important County Medical Societies (Calhoun, Genesee, St. Clair) have elected not to participate in the MSMS program.

Cumulative statistics, as of December 31, 1956, reflect the combined activity of all the MSMS Centers:

New Admissions	3,825
Diagnosed rheumatic fever/rheumatic heart disease	1,394
Re-examinations and follow-up	2,602
Total examinations made	6,427

Analysis of the complete statistical report shows that there is extreme variability among the several Centers, from total inactivity to considerable progress. Three Centers (Grand Rapids, Kalamazoo, Traverse City) account for nearly 50 per cent of new admissions to the program. Among the reasons for this variability are: a genuine belief that there is no need for a diagnostic program; indifference to the problems of rheumatic fever; misunderstanding of the objectives of the project. The more successful County Medical Societies are to be commended for their important contribution to the MSMS program.

CONCLUSION

While it cannot be said that on a statewide basis the Rheumatic Fever Control Program of the MSMS has been 100 per cent successful, it is readily apparent that a great deal of progress has been made in the twelve years of its existence. There is now much more awareness of and interest in the problems of rheumatic fever and of rheumatic heart disease, both on the part of the medical profession and on the part of the public, than there was in 1945. This, of course, is the implied final objective of the project. The progress made in the past few years should not be allowed to regress, but a continued sustained effort should be maintained for its enlargement.

The success of a program such as this reflects favorably upon the Michigan medical profession in the eyes of the public.

RECOMMENDATIONS

Your medical coordinator respectfully submits the following recommendations for consideration by the Council:

1. Continuation and expansion of the MSMS Rheumatic Fever Control Program as presently constituted and as guided by the Rheumatic Fever Control Committee; i.e., (a) education, both lay and professional; (b) diagnostic and consultation service to the practicing physician at his request.

2. Moral support and continued financial assistance to those Rheumatic Fever Centers which are now actively engaged in rheumatic fever control and desire to continue and expand their programs.

3. Maintaining an open door to those Medical Societies who may wish to participate in the MSMS program at a later date.

4. Financial support of the Postgraduate Education Program (Postgraduate Fellowships) and extension of this program to attendance at recognized rheumatic fever centers elsewhere in the U.S.A., without formal course, in selected cases.

5. Maintaining the position of Medical Coordinator on either a full-time or a part-time basis, with the provision that the medical coordinator shall reside in the Southeastern part of the State, for the reason that most doctors and a large segment of the population are concentrated in that area.

6. Maintaining good relations and cooperation with the Rheumatic Fever Programs of the Michigan Crippled Children Commission and of the Michigan Department of Health.

7. Maintaining good relations and cooperation with the Michigan Heart Association, which not only supports the MSMS program financially, but is itself a voluntary organization engaged in the fight against heart disease, and has delegated the major share of its interest in the problems of rheumatic fever to the Michigan State Medical Society.

Respectfully submitted,
LEON DEVEL, M.D.
Medical Coordinator

MSMS RHEUMATIC FEVER CONTROL COMMITTEE

Statistical Report from January 1, 1956, to December 31, 1956

	*Total Register Jan. 1, 1956				Jan. 1, 1956, to Dec. 31, 1956				*Total Register Dec. 31, 1956			
	No. Adm.	Rh. F.	Reex.	Total	No. Adm.	Rh. F.	Reex.	Total	No. Adm.	Rh. F.	Reex.	Total
Center**	125	53	25	150	14	11	5	19	139	64	30	169
Alpena (19)	225	197	265	490	18	34	62	80	243	231	327	570
Ann Arbor (6)	219	80	89	308	10	5	3	13	229	85	92	321
Bay City (9)	25	8	4	29	0	0	0	0	25	8	4	29
Benton Harbor (14)	277	45	6	283	35	9	2	37	312	54	8	320
Detroit-Wayne (1)	677	261	496	1173	45	14	33	78	722	275	529	1251
Grand Rapids (3)	136	45	28	164	3	3	0	3	139	48	28	167
Jackson (15)	528	168	567	1095	60	15	67	127	588	183	634	1222
Kalamazoo (10)	107	13	20	127	8	0	0	8	115	13	20	135
Lansing (5)	—	—	—	—	INACTIVE			—	—	—	—	—
Marquette (8)	245	79	195	440	6	4	10	16	251	83	205	456
Muskegon (11)	23	21	16	39	INACTIVE			—	23	21	16	39
Petoskey (18)	239	55	88	327	16	5	6	22	255	60	94	349
Pontiac-Royal Oak (2)	91	27	8	99	INACTIVE			—	91	27	8	99
Saginaw (7)	—	—	—	—	INACTIVE			—	—	—	—	—
Sault Ste. Marie (17)	647	199	552	1199	46	43	55	101	693	242	607	1300
Traverse City (13)	—	—	—	—	—	—	—	—	—	—	—	—
TOTALS	3564	1251	2359	5923	261	143	243	304	3825	1394	2602	6427

*Cases and examinations on record from the beginning of the Center's activities.
**Number indicates rank of importance according to population.

UNORGANIZED CENTERS: Battle Creek (12)
Flint (4)
Port Huron (16)

MSMS 1957 BUDGET ESTIMATES

GENERAL FUND

ACCOUNT TITLE	1957 Estimate
INCOME	
5250 members @ $55.00	$288,750.00
Less: $1.50 to THE JOURNAL	7,875.00
$6.25 to Public Education	32,812.50
$3.50 to Public Service	18,375.00
$5.25 to Professional Relations	27,562.50
$5.00 to MSMS New Headquarters Fund	26,250.00
$2.00 to Building Maintenance Fund	10,500.00
$3.00 to Public Education Reserve	15,750.00
Balance to General Fund @ $28.50	$149,625.00
Interest and Miscellaneous Income	—0—
TOTAL FUNDS AVAILABLE	$149,625.00
EXPENSES (Administrative and General)	
Printing, Mailing and Postage	$ 10,000.00
Office Supplies	3,000.00
Insurance and Bonds	5,000.00
Auditing	750.00
Salaries: Administrative and Office	37,000.00
General Counsel Retainer and Expense	7,000.00
Equipment and Repairs	3,500.00
Telephone and Telegraph	4,000.00
Taxes (Other than Property)	2,500.00
Miscellaneous Expenses and Contributions	3,000.00
Employe's Retirement Trust	10,000.00
Resident's and Interns Conference	—0—
Total Administrative and General Expense	$ 85,750.00
EXPENSES (Society Activities)	
Council Expense	$ 15,000.00
AMA Delegates and Alternates	7,000.00
General Society Travel and Entertainment	7,200.00
Officers Travel	6,200.00
Secretary's Letters and Office Expense	900.00
Woman's Auxiliary	600.00
Dues Collection Expense	3,000.00
Total Society Activities	$ 39,900.00
EXPENSES (Committees)	
Cancer Coordinating Committee	$ 1,000.00
Child Welfare Committee	400.00
National Defense	400.00
Geriatrics	500.00
Industrial Health	100.00
Legislative	1,500.00
Maternal Health	400.00
Mental Health	400.00
Michigan Health Council	10,000.00
Postgraduate Medical Education	4,000.00
Preventive Medicine	100.00
Permanent Conference	100.00
Rural Medical Service	200.00
Scientific Radio	1,400.00
Tuberculosis Control	200.00
Venereal Disease	100.00
Beaumont Memorial Restoration	500.00
Highway Accident Committee	400.00
Sundry Committee Expense	2,000.00
Total Committee Expense	$ 23,700.00
TOTAL GENERAL FUND EXPENSES	$149,350.00
GAIN FOR THE YEAR	275.00
BALANCE FROM PRIOR YEARS	89,870.56
	$ 90,145.56
NET GAIN OR LOSS FROM ANNUAL SESSION, MCI AND JOURNAL	—0—
BALANCE TO 1958	$ 90,145.56

BUILDING MAINTENANCE FUND

INCOME	
Allocation from membership dues	$ 10,500.00
EXPENSES	
Maintenance: Utilities, Decorating, supplies, yard work, etc.	$ 3,000.00
Salaries: Janitor	2,000.00
Property Taxes	850.00
Insurance: Fire and Liability	500.00
Depreciation	1,750.00
Furnishings	200.00
Remodeling	200.00
Parking Area	—0—
Miscellaneous	—0—
Total Building Maintenance Expense	$ 8,500.00
GAIN FOR THE YEAR	2,000.00
BALANCE FROM PRIOR YEARS	14,124.94
BALANCE TO 1958	$ 16,124.94

ANNUAL SESSION

INCOME	
Booth Sales: 132 Spaces	$ 29,000.00
EXPENSES	
Scientific Meeting Expense	$ 4,500.00
Exhibit Expense	5,000.00
Registration and Hotel Expense	800.00
State Society and Officers Night	4,200.00
Promotion: Printing, Mailing, Postage and Scientific Work Committee	3,300.00
Press Expense	1,400.00
Salaries	8,000.00
House of Delegates Expense (including Special Guests)	2,200.00
Miscellaneous Expense	1,600.00
Total Annual Session Expense	$ 31,000.00

MSMS NEW HEADQUARTERS FUND

INCOME	
Allocation from membership dues	$ 26,250.00

CONTINGENT FUND

INCOME	
Allocation from membership dues	$ —0—
Balance from prior years	53,614.34
Total	$ 53,614.34

MICHIGAN CLINICAL INSTITUTE

INCOME	
Booth Sales: 74 Spaces	$ 13,650.00
EXPENSES	
Scientific Meeting	$ 2,500.00
Exhibit Expense	3,500.00
Registration and Hotel	900.00
Promotion: Printing, Mailing, Postage and Committee meetings	3,300.00
Press Expense	1,300.00
Salaries	1,950.00
Residents and Interns Conference	—0—
Miscellaneous Expenses	200.00
Total MCI Expense	$ 13,650.00

THE JOURNAL

INCOME	
Allocation from membership dues	$ 7,875.00
Subscriptions—non-members	800.00
Advertising Sales	80,000.00
Reprint and Cut Sales	4,000.00
Miscellaneous Income	100.00
Total Income	$ 92,775.00
EXPENSES	
Editor's Expense	$ 3,000.00
Printing, Mailing and Postage	54,000.00
Reprint and Cut Expense	3,500.00
Salaries	14,550.00
Discounts and Commissions	19,400.00
Miscellaneous Expenses	125.00
Total Expenses	$ 94,575.00

PUBLIC EDUCATION RESERVE

INCOME	
Allocation from membership dues	$ 15,750.00
Balance from prior years	57,245.00
Total	$ 72,995.00

PUBLIC SERVICE ACCOUNT

INCOME	
Allocation from membership dues	$ 18,375.00
EXPENSES	
Salaries	$ 18,150.00
Telephone and Telegraph	1,000.00
Travel and Entertainment	5,000.00
Rural Health Conference	250.00
Miscellaneous Expense	—0—
Committee meetings	100.00
Total Expenses	$ 24,500.00
LOSS FOR THE YEAR	6,125.00
BALANCE FROM PRIOR YEARS	3,675.16
BALANCE TO 1958 (Loss)	$ 2,449.84

PUBLIC EDUCATION ACCOUNT

INCOME	
Allocation from membership dues	$ 32,812.50
Other Income	—0—
Total Income	$ 32 812.50
EXPENSES	
Committee meetings	$ 500.00
Equipment and Repairs	500.00
Printing, Mailing and Postage	2,500.00
Office Supplies	1,000.00
Salaries	18,350.00
Telephone and Telegraph	1,500.00
Travel and Entertainment	5,000.00
Exhibit Expenses	1,000.00
Publications, Pamphlets, clippings	1,000.00
Radio, TV and Cinema	10,000.00
Miscellaneous Expense	600.00
Total Expenses	$ 41,950.00
LOSS FOR THE YEAR	$ 9,137.50
BALANCE FROM PRIOR YEARS	$ 73,891.87
BALANCE TO 1958	$ 64,754.37

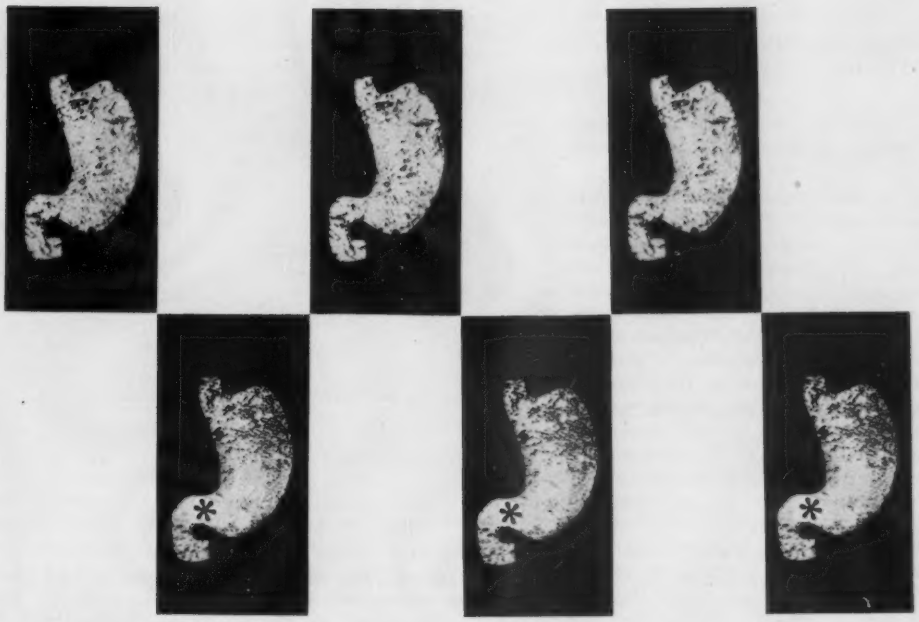
PROFESSIONAL RELATIONS

INCOME	
Allocation from membership dues	$ 27,562.50
EXPENSES	
Rent to Wayne County Medical Society	$ 720.00
Salaries	18,150.00
Telephone and Telegraph	1,000.00
Travel and Entertainment	5,000.00
National Meeting Expense	2,000.00
County Secretary's—PR Conference	6,000.00
County Society and Field Secretary meetings	1,000.00
Woman's Auxiliary	1,000.00
Miscellaneous Expenses	100.00
Committee Meetings	—0—
Printing, Mailing and Postage	750.00
Total Expenses	$ 35,720.00
LOSS FOR THE YEAR	8,157.50
BALANCE FROM PRIOR YEARS	4,897.50
BALANCE TO 1958 (Loss)	$ 3,260.00

RHEUMATIC FEVER CONTROL PROGRAM

INCOME	
From Michigan Heart Association	$ 39,574.44
EXPENSES (Central Office)	
Committee meetings	$ 500.00
Equipment and Repairs	2,500.00
Payroll Taxes	300.00
Printing, Mailing and Postage	1,750.00
Office Supplies	200.00
Publications and Pamphlets	100.00
Salaries: Administrative and Office	11,600.00
Travel	1,500.00
Fellowships	3,000.00
Telephone and Telegraph	100.00
Laboratory Aid Plan	1,000.00
Travel Fellowships	3,000.00
Annual Rheumatic Fever Day	4,000.00
Circulating Exhibits	3,000.00
Total Central Office Expense	$ 32,550.00
EXPENSES (Control Centers)	
Alpena	$ 500.00
Ann Arbor	1,500.00
Bay City	1,000.00
Benton Harbor	200.00
Detroit	4,000.00
Grand Rapids and Muskegon	4,000.00
Jackson	100.00
Kalamazoo	1,500.00
Lansing	100.00
Petoskey	100.00
Pontiac and Royal Oak	200.00
Saginaw	200.00
Sault Ste. Marie	100.00
Traverse City	1,200.00
Total Control Center Expenses	$ 14,700.00
Total Rheumatic Fever Expenses	47,250.00
LOSS FOR THE YEAR	7,675.56
BALANCE FROM PRIOR YEARS	$ 7,675.56

TRUE ANTICHOLINERGIC ACTION



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Michigan's Department of Health

Albert E. Heustis, M.D., Commissioner

IN-SERVICE TRAINING IMPROVES HEALTH PROGRAM

Continuing and intensive in-service training for personnel of local and state health departments in Michigan is carried on by the Michigan Department of Health.

All of the specialties involved in the program of the Michigan Department of Health, administration, public health dentistry, public health nursing, sanitation, occupational health, laboratory, statistics, nutrition, health education and clerical work, are represented on the Co-ordinating Committee that conducts the training program. Dr. J. K. Atland, Director of the Division of Local Health Administration, is chairman of this committee. Working under the Co-ordinating Committee are technical committees in each specialty, headed by division directors or section chiefs of the state department and made up of representatives of state and local health departments and interested individuals. The technical committees are responsible for recruitment as well as training.

Much of the in-service training is informal and non-accredited, covering a broad scope of interests. A total of 1,250 state and local health department workers took part in some way in activities sponsored in 1955-56. Examples of non-accredited training offered this year were: institutes of varying length on subjects such as long-term illness; workshops for local health department nurses, sanitarians and clerks; courses in public administration for supervisory personnel and courses for water and sewage treatment plant operators.

In the accredited training program, a limited number of fellowships for advanced study are available each year to state and local health department personnel. In general, the fellowships are considered a bonus given to persons already in the field of public health who have demonstrated a capacity for growth and a dedication to their work. The grants are not used as a means of recruiting new persons for the profession. The training enables a person to fill a need identified as important in the position which he holds.

About fifteen persons receive the one-year fellowships awarded annually. Winners of the grants this year included public health physicians, nurses, sanitarians and laboratorians. Most of the fifteen are studying toward master's degrees in public health at the School of Public Health of the University of Michigan.

Persons applying for fellowships are first screened by the technical committees. On the basis of its findings, each committee makes recommendations to the Co-ordinating Committee on the applicants in its specialty.

In its final choice of candidates to be recommended to the State Health Commissioner for fellowships, the Co-ordinating Committee works through a Fellowship Selection Committee. On this committee are representatives of the specialties found in the Michigan Department of Health and also local health department staff members.

The Fellowship Selection Committee interviews all applicants and on the basis of its findings and the recommendations of the technical committees submits names to the State Health Commissioner in the order of choice. The Commissioner makes final selections.

The state-administered program of advanced training is independent of the fellowship program being conducted by the U. S. Public Health Service. Goal of the federal program is to attract newcomers to the field of public health. The two programs are supplementary and have the single objective of meeting the demands for more and better qualified public health personnel.

VENEREAL DISEASE POSTGRADUATE CONFERENCE

The 26th Venereal Disease Postgraduate Conference for physicians sponsored by the University of Tennessee College of Medicine, the Public Health Service and the Tennessee State Department of Health will be held at the College of Medicine in Memphis, April 18-20. No tuition will be charged. Applications for admission are to be sent to Dr. Henry Packer, Department of Preventive Medicine, College of Medicine, University of Tennessee, Memphis 3, Tennessee.

PROPHYLACTICS FOR EYES OF NEWBORN

Frequent inquiries are received from physicians as to prophylactics to be used in the eyes of newborn infants.

Michigan law requires the State Health Commissioner "to officially name and approve a prophylaxis to be used in treating the eyes of newly born infants."

In compliance with this law, the State Council of Health approved silver nitrate, 1.0 per cent in solution, as the prophylactic to be used in every child's eyes immediately after birth.

A change in regulations concerning eye prophylaxis was made in 1953. The use of prophylactics other than silver nitrate may be permitted under controlled research conditions when such research studies have been previously approved by the State Health Commissioner.

In an analysis of 1,000 cases of pelvic cancer, *physician delay* was established in 158, and delay on the part of both physician and patient in 437.

* * *

It seems incredible that any medical graduate would not know that postmenopausal or intermenstrual bleeding might and often does mean cancer, and that only a proper examination can throw light on the cause of the bleeding.

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In Memoriam

Jacob D. Brook, M.D., eighty, of Grandville, died December 20, 1956, at Grand Rapids.

Doctor Brook was a Past President of the Michigan State Medical Society, having served as chief executive in 1929.

Born in 1877 at Cleveland, Ohio, Doctor Brook came to Grandville in 1892. After receiving his M.D. degree from Detroit College of Medicine (now Wayne State University) in 1902, he began general practice in Grandville and continued for twenty-nine years until he became Kent County's first fulltime health officer.

Doctor Brook also served as President of the Kent County Medical Society, the Michigan State Board of Registration in Medicine and the Michigan Public Health Association. He was a member of the American Medical Association and served as Michigan delegate to the AMA House of Delegates for twenty-four years.

* * *

Samuel Balofsky, M.D., forty-seven, Detroit, Associate Professor of Radiology at Wayne State University College of Medicine, was a member of Wayne County Medical Society and a staff member at Receiving and Detroit Memorial Hospitals, Detroit. Dr. Balofsky died August 11, 1956.

* * *

Robert Beattie, M.D., eighty-five, retired Detroit physician, was a 1903 graduate of the Detroit College of Medicine (Wayne University). He had practiced in Detroit fifty-two years before he retired in 1955. He was a member of the Wayne County Medical Society and a Life Member of the Michigan State Medical Society. He died August 18, 1956.

* * *

Robert J. Biggar, M.D., forty-seven, formerly of Port Huron, was chief medical officer for the California Texas Oil Company, Ltd. He received his M.D. degree from the Detroit College of Medicine (Wayne University) in 1936. He was a member of the St. Clair County Medical Society. He died September 21, 1956.

* * *

P. W. Butterfield, M.D., forty-seven, pathologist at Alpena General Hospital, Alpena, was born in 1909 in East Wilton, Maine. He received his M.D. degree from Boston University Medical School, and had practiced in Alpena for three years. He died October 19, 1956.

* * *

Wm. A. Evans, M.D., forty-nine, Detroit physician for more than twenty years, was a native of Bellaire, and had lived in Detroit for forty-five years. He was graduated from the Johns Hopkins Medical School, and was a member of the Wayne County Medical Society. He died October 17, 1956.

* * *

Daniel P. Foster, M.D., sixty-four, Detroit, head of Henry Ford Hospital's metabolism department, received his M.D. degree from Harvard Medical School in 1922. Dr. Foster was a member of the Wayne County Medical Society. He died August 21, 1956.

* * *

Leonard Fox, M.D., thirty-three, of Wyandotte, was born in Canada. Dr. Fox graduated from the University of Michigan Medical School in 1945. He had practiced in Wyandotte for four years. He died October 7, 1956.

* * *

John R. Giffen, M.D., eighty-five, practitioner in Bangor for over sixty years, was born in Mayfield, Ontario, Canada, in 1870. He received his M.D. degree at Willamette University, Willamette, Oregon. Dr. Giffen was a member of the Van Buren County Medical Society, and an Emeritus Member of the Michigan State Medical Society. He died July 24, 1956.

* * *

W. T. S. Gregg, M.D., eighty-five, of Eagle Harbor, practicing physician for over half a century, was born in 1871, in Southfield, Michigan. Dr. Gregg retired from practice in 1946. He was a member of the Houghton-Baraga-Keweenaw County Medical Society and an Emeritus Member of the Michigan State Medical Society. He died July 15, 1956.

* * *

Arthur J. Hamilton, M.D., fifty-eight, of Flint, was born in 1898, in Tecumseh. He was graduated from the University of Tennessee Medical School. He was a member of the Genesee County Medical Society, and had practiced in Detroit prior to coming to Flint ten years ago. He died August 11, 1956.

* * *

William Hamilton, M.D., sixty-six, of Highland Park, was born near Huntsville, Ontario. Dr. Hamilton received his M.D. degree from the University of Toronto in 1916. He had practiced in Detroit for forty years following his graduation. He died August 2, 1956.

* * *

Robert B. Hasner, M.D., seventy-two, of Royal Oak, was born in Independence, Iowa. Dr. Hasner received his M.D. degree from Rush Medical College. He had practiced medicine in Royal Oak for thirty-five years. He was a Past President of the Oakland County Medical Society, and a Life Member of the Michigan State Medical Society. He died September 16, 1956.

Arthur R. Hayton, M.D., seventy-eight, practicing physician in Shelby since 1905, was born in New York City in 1878. He received his M.D. degree from the University of Illinois in 1905. He was a member of the Oceana County Medical Society and a Life Member of the Michigan State Medical Society. He died December 27, 1956.

* * *

Ara B. Hewes, M.D., eighty-two, well-known Adrian physician and surgeon, was born in 1873, at Medina, Ohio. He received his M.D. degree from the Cleveland Homeopathic Medical College in 1903. Dr. Hewes had practiced in Adrian for more than fifty years, beginning his first practice here in 1903. He was a Past President of the Lenawee County Medical Society. He died July 30, 1956.

* * *

J. E. Hopkins, M.D., fifty-nine, Detroit, staff physician at Lincoln Hospital, was born in Canada. Dr. Hopkins received his M.D. degree from the University of Toronto Medical School. He was a member of the Wayne County Medical Society. He died suddenly November 25, 1956.

* * *

Ralph G. Hubbard, M.D., fifty-eight, of Detroit, was born in New Baltimore. Dr. Hubbard had lived in Detroit since 1915. He was graduated from the University of Michigan Medical School in 1926. He was a member of the Wayne County Medical Society and an Associate Member of the Michigan State Medical Society. He died August 31, 1956.

* * *

E. S. Huckins, M.D., sixty-four, Bay City practitioner since 1916, was born in Bay City in 1892. He was graduated from the University of Cincinnati Medical School in 1915. He was a Past President of the Bay County Medical Society and a Retired Member of the Michigan State Medical Society. He died December 29, 1956.

* * *

Ned B. Kalder, M.D., forty-three, Chief of Staff at Mt. Carmel Mercy Hospital, Detroit, was a member of Wayne County Medical Society. He died in a traffic accident July 15, 1956.

* * *

John L. Loomis, M.D., retired member of the Muskegon County Medical Society, was graduated from the University of Pennsylvania Medical School, and practiced in Muskegon, Michigan, until illness forced his retirement. He died May 1, 1956, in Santa Ana, California.

* * *

J. L. McKenna, M.D., fifty-four, Grand Rapids physician and surgeon, was a native of Ionia. Dr. McKenna had been a resident of Grand Rapids most of his life, receiving his M.D. degree from the University of Michigan in 1926. He was a member of the Kent County Medical Society. He died August 25, 1956.

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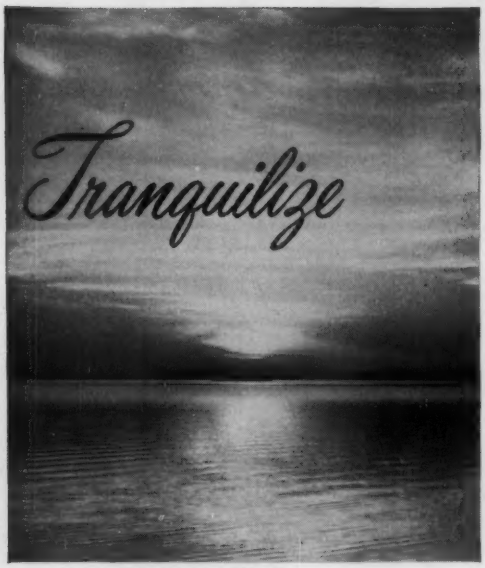

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Henry G. Merz, M.D., eighty-six, of Lapeer, was born in 1869 at Castroville, Texas. He graduated from Homeopathic College, Chicago, in 1892. He had practiced medicine for sixty-four years; in Lapeer, for the past thirty-one years. He was a member of the Lapeer County Medical Society and an Emeritus Member of the Michigan State Medical Society. He died September 22, 1956.

* * *

John P. Parsons, M.D., sixty-seven, of Grosse Pointe Park, was a native of Eau Claire, Wisconsin. Dr. Parsons was graduated from the University of Michigan Medical School in 1919. He had practiced in Detroit since 1934, and was a member of the Wayne County Medical Society. He died September 17, 1956.

* * *

Edwin M. Smith, M.D., sixty, Grand Rapids physician since 1926, was born near Brown City. He received his M.D. degree from the University of Michigan, and was a member of the Kent County Medical Society. He died August 3, 1956.

* * *

W. C. Swartout, M.D., seventy-six, of Muskegon, a medical practitioner for more than fifty years, was born in 1880 at Chicago. Dr. Swartout was graduated from the University of Illinois School of Medicine and practiced in Chicago prior to coming to Muskegon in 1919. He was a Life Member of the Michigan State Medical Society, and a member of the Muskegon County Medical Society. He died October 22, 1956.

* * *

John J. Walch, M.D., sixty-nine, of Escanaba, retired physician and surgeon, was born in 1887 in Escanaba. He received his M.D. degree from the University of Michigan in 1912. He had practiced in Escanaba from 1915 until his retirement. Dr. Walch was a Past President of the Delta-Schoolcraft County Medical Society and a long-time member of the MSMS House of Delegates. He died September 5, 1956.

* * *

Harold W. Wiley, M.D., sixty-seven, of Lansing, director of procurement and distribution of blood for Michigan Department of Health since 1952, was born in 1889, in Lansing. Dr. Wiley obtained his M.D. degree from the University of Michigan. He was in private practice in Lansing for twenty-seven years until 1950. Doctor Wiley was a Past President of the Ingham County Medical Society and former Delegate from Ingham County to the MSMS House of Delegates. He died suddenly July 15, 1956.

Just as other disease processes has been coped with when not every mechanism of their induction was understood, so advantage must be taken of the existing knowledge of environmental cancers.

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Correspondence

Dear Mr. Burns:

I have just returned from the National Trauma Committee Meeting of the American College of Surgeons which was held in Cleveland on the 1st and 2nd of February.

I am very pleased to report that for the sixth time in the past seven years the Michigan report on educational activities concerned with trauma was given first place. Credit for this achievement must be given to all of the Michigan physicians who co-operated so well in all of the educational activities of this committee, and especially to the many local committee chairmen who sponsored such fine programs throughout the year.

I want to thank you very kindly for your help in publishing some of our trauma papers in the August issue on Trauma and for the fine publicity which you gave us throughout the year in the State Journal. It is the hope of the Trauma Committee that you will continue to aid our efforts and that we may remain in first place when the National Committee meets next year in Florida.

Sincerely yours,
HOMER M. SMATHERS, M.D.,
Chairman, Michigan Regional Committee on Trauma,
American College of Surgeons

Detroit, Michigan
February 7, 1957

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MICHIGAN AUTHORS

Henry J. Montoye, Ph.D., Wayne D. Van Huss, Ph.D., Herbert Olson, M.S., Andrew Hudec, M.S. and **Earl Mahoney, M.S.**, East Lansing, are the authors of an article entitled "Study of the Longevity and Morbidity of College Athletes" published in *The Journal of the American Medical Association*, November 17, 1956.

R. W. Waggoner, M.D., Ann Arbor, is the author of an article entitled "History of the Department of Psychiatry at the University of Michigan," presented before the Sixth Triennial Medical Alumni Conference in Ann Arbor, September, 1956, and published in *University of Michigan Medical Bulletin*, October, 1956.

Thomas Francis, Jr., M.D., Ann Arbor, is the author of an article entitled "Approaches to the Prevention of Poliomyelitis," published in the *University of Michigan Medical Bulletin*, October, 1956.

Ross V. Taylor, M.D., Jackson, is the author of an article entitled "Amebiasis Treated with Biallylamicol Hydrochloride," published in the *American Journal of Gastroenterology*, December, 1956.

R. Patterson, M.D., and **W. A. Gracie, M.D.**, Ann Arbor, are the authors of an article entitled "The Rapid Approximation of Plasma Glucose by Means of Indicator Tape," published in the *University of Michigan Medical Bulletin*, October, 1956.

John S. De Tar, M.D., Milan, is the author of an article published in *GP* for November, 1956, which is the text of the Dedication Address given on September 1, 1956, at the formal dedication of the new national headquarters building of the Academy for General Practice, of which Dr. De Tar is President.

Robert S. Knighton, M.D., and **J. DeWitt Fox, M.D.**, Detroit, are the authors of an article entitled "Diagnosis and Treatment of Eosinophilic Granuloma of Skull," published in *The Journal of the American Medical Association*, December 1, 1956.

John T. Ferguson, M.D., Frank V. Z. Linn, M.D., John A. Sheets, Jr., M.D., and **Mervyn M. Nickels, M.D.**, Traverse City, are the authors of an article entitled "Methylphenidate (Ritalin) Hydrochloride Parenteral Solution," published in *The Journal of the American Medical Association*, December 1, 1956.

H. G. Kobrak, M.D., Detroit, is the author of an article entitled "Objective Audiometry," which was published in the AMA *Archives of Otolaryngology*, January, 1957.

Irving Shapire, M.D., Ann Arbor, is the author of an article entitled, "Radioactive Phosphorus in Differential Diagnosis of Ocular Tumors," presented at the scientific session following the Third National Cancer Conference, Thursday, June 7, 1956, Ann Arbor, and published in AMA *Archives of Ophthalmology*, January, 1957.

M. K. Newman, M.D., Detroit, is the author of an article entitled, "Electromyography in Neurological Diagnosis," appearing in the *Annals of Rehabilitation*, Vol. III, Mexico City, Mexico.

Edward W. Kelly, Jr., M.D., and **Hermann Pinkus, M.D.**, Detroit, are the authors of an article entitled "Local Application of 8-Methoxypsoralen in Vitiligo," published in the *Journal of Investigative Dermatology*, December, 1955.

Rosie Hunter, Herman Pinkus, M.D., and **Catherine Heise Steele, M.D.**, Detroit, are the authors of an article entitled, "Examination of the Epidermis by the Strip Method," published in the *Journal of Investigative Dermatology*, July, 1956.

Hermann Pinkus, M.D., Monroe, and **James R. Rogin, M.D.**, and **Perry Goldman, M.D.**, Detroit, are the authors of an article entitled "Eccrine Poroma" and published in AMA *Archives of Dermatology*, November, 1956.

Hermann Pinkus, M.D., and **Catherine Heise Steele, M.D.**, Detroit, are the authors of an article and exhibit entitled "Structure and Dynamics of the Human Epidermis," published in AMA Scientific Exhibits, 1955, Grune and Stratton, Publishers. The exhibit was shown at the American Academy of Dermatology and Syphilology, Chicago in 1954 and at the AMA meeting, Atlantic City in 1955, where it received Honorable Mention in the Section of Dermatology.

Carey P. McCord, M.D., Ann Arbor, is the author of an article entitled, "The Blind Hog in the British Isles," published in *Industrial Medicine and Surgery*, January, 1957.

W. E. Rush, M.D., J. P. Truant, M.D., J. C. Sieracki, M.D., and **G. Manson, M.D.**, Detroit, are the authors of an article entitled "Actinomycosis-Cerebral Infection Presenting as a Brain Tumor," published in *Henry Ford Hospital Medical Bulletin*, December, 1956.

Shirley A. Johnson, Ph.D., M. June Caldwell, B.A., and **Edward McCall Priest, M.D.**, Detroit, are the authors of an article entitled, "The Effect of the Administration of the Anticoagulant Marcumar on the Blood Coagulation Mechanisms," published in *Henry Ford Hospital Medical Bulletin*, December, 1956.

Robert F. Ziegler, M.D., Detroit, is the author of an article entitled "The Electrocardiogram in Interatrial Septal Defect," presented before the VIIIth International Congress of Pediatrics, Copenhagen, Denmark, July, 1956, and published in *Henry Ford Hospital Medical Bulletin*, December, 1956.

Fred W. Whitehouse, M.D., Detroit, is the author of an article entitled, "The Clinical Value of the Plasma Acetone Test," published in the *Henry Ford Hospital Medical Bulletin,* December, 1956.

Joseph Beninson, M.D., Detroit, is the author of an article entitled "Preliminary Report on the use of a Pressure Gradient, Elastic Support in Conditions Associated with Impaired Vascular Reserve," presented before the Central States Dermatological Association, Henry Ford Hospital, April, 1956, a résumé of which is published in the *Henry Ford Hospital Medical Bulletin,* December, 1956.

Hugh W. Brenneman, Lansing, is the author of an article entitled "Are Professions on Their Way Out?" published in *The New Physician,* January, 1957.

J. Chandler Smith, M.D., Saginaw, is the author of an article entitled "The Treatment of Cancer of the Breast, published in *Surgery, Gynecology and Obstetrics,* January, 1957.

E. R. Jennings, M.D., and **J. W. Landers, M.D.,** Detroit, are the authors of an article entitled "The Use of Frozen Section in Cancer Diagnosis," published in *Surgery, Gynecology and Obstetrics,* January, 1957.

A. Waite Bohne, M.D., and **Dale R. Drew, M.D.,** Detroit, are the authors of an article entitled "A Comparative Evaluation of Intravenous Pyelographic Media," published in AMA *Archives of Surgery,* December, 1956.

Robert C. Hendrix, M.D., Ann Arbor, is the author of an article entitled "Neoplasm in Children: A Review of Necropsy Records in 244 Cases," published in *University of Michigan Medical Bulletin,* November, 1956.

John G. Batsakis, M.D., Ann Arbor, is the author of an article entitled "Calcospherites and Thyroid Carcinoma," published in the *University of Michigan Medical Bulletin,* November, 1956.

Robert M. Nalbandian, M.D., Seymour Gordon, M.D., Ruth Campbell, M.D., and **J. M. Kaufman, M.D.,** are the authors of an article entilted "A New Quantitative Digitalis Tolerance Test," published in *Harper Hospital Bulletin,* November-December, 1956.

Maria Huebbe, M.D., and **Irving F. Burton, M.D.,** Detroit, are the authors of an article entitled "Tuberculosis of the Cervical Lymph Glands," published in *Harper Hospital Bulletin,* November-December, 1956.

William S. Carpenter, M.D., and **Paul J. Connolly, M.D.,** Detroit, are the authors of an article entitled "Surgical Treatment of Ulcerative Colitis," published in *Harper Hospital Bulletin,* November-December, 1956.

B. Berglund, M.D., and **A. Kohlmeier, M.D.,** Detroit, tre the authors of an article entitled "An Analysis of Fatality," published in *Harper Hospital Bulletin,* November-December, 1956.

E. S. Gurdjian, M.D., F.A.C.S., and **J. E. Webster, M.D., F.A.C.S.,** Detroit, are the authors of an article entitled "Experiences in the Surgical Management of Intrcranial Suppuration," published in *Surgery, Gynecology and Obstetrics,* February, 1957.

Donald C. Durman, M.D., Saginaw, is the author of an article entitled "Metatarsus Primus Varus and Hallux Valgus," read before the Section on Orthopedic

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1. Pollock, B. E., and Pruitt, F. W.: Am. J. M. Sc., 226:172, 1953.

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Surgery at the 105th Annual Meeting of the American Medical Association, Chicago, June, 1956, and published in AMA *Archives of Surgery*, January, 1957.

George L. Waldbott, M.D., Detroit, is the author of an article entitled "Incipient Fluorine Intoxication from Drinking Water," published in *Acta Medica Scandinavica*, Vol. CLVI, fasc. III, 1956.

* * *

Elmer Hess, M.D., Immediate Past President of the A.M.A., speaking on the role of the physician in Blue Shield, at Seattle and the Interim Session of the American Medical Association, said:

"Without Blue Cross and Blue Shield and other insurance programs our hospitals and ourselves would be hard put to render the services that these two organizations have made possible. Since we have accepted the insurance principle many patients would previously be non-paying patients have had their bills at least partly paid. . . . Today's professional freedom to be a private practitioner of medicine instead of a slave of government is due solely to Blue Shield, the physician's answer to 'Socialized Medicine.'"

* * *

General practitioners are taking an increasingly important role in the treatment of mental illness. As more and more patients are able to leave psychiatric hospitals, due in part to the use of tranquilizing drugs, much of the follow-up care and maintenance therapy falls to the family physician. In order to aid co-operation between the discharged patient and his family physician, a discharged patient booklet, entitled "A New Chapter," has been prepared which the State Mental Hospitals at their discretion will give to the home-going patient. (Available from Smith Klein and French.)

* * *

The Centennial Exposition commemorating the 100th anniversary of the Academy of Medicine of Cincinnati, February 27-March 5, in Music Hall, included an exhibit of the Ohio Valley Civil Defense Authority, illustrating a typical 200-bed emergency hospital.

The exhibit, along with the entire Centennial Exposition's 175 booth unit attractions has been obtained from the national Civil Defense authority for showing in Cincinnati.

* * *

The American Orthopsychiatric Association will hold its 34th Annual Meeting at the Hotel Sherman in Chicago on March 7, 8, 9, 1957.

* * *

Polio Vaccine.—During the 1956 vaccine manufacturers brought supply up to meet demand. The 100,000,000th cubic centimeter of Salk vaccine was released by the U. S. Public Health Service in Washington in mid-September. There are no more priorities on use of commercial vaccine. It is available for all who want it.

Performance of the Salk vaccine up to now suggests a potential effectiveness among persons who have received all three shots, properly spaced, of about 90 per cent. With only one shot, one cannot be sure that one is safe or that the immunization will last after the first; a second shot increases's one's chance of being among the immunized. The third shot, given seven months

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after the second, further increases one's chances of being safe and it prolongs the term of safety, perhaps for years.

* * *

Lt. Col. Herschel E. Griffin, Chief of the Communications Branch, in reviewing the cause of non-effectiveness in the army, reports that three fourths of all deaths in the army are due to injury. Accidents, as in civil life, are the greatest cause of time loss. One half of all injuries are due to automobiles. The army has cut down the presence of communicable disease, which naturally has increased the proportion of accidents.

* * *

Career Incentive.—The Department of Defense has found its incentive for retaining medical officers in the armed forces has been somewhat effective. From July 1, 1956, to November 30, the medical Corps of the Army, Navy, and Air Forces showed a net gain in strength of 251. This compares with a gain of 73 in the previous year, and a loss the year before of 291. The Dental Corps shows a like change.

* * *

Any combat veteran awarded the Purple Heart would be deemed to be 10 per cent disabled from service-connected causes under a bill (H.R. 330) by Rep. McDonough (R., Calif.). This disability rating would be in addition to any other disability rating VA had established for the veteran. The effect would be to make every Purple Heart winner a service-connected case for purposes of medical care; the "availability of space" restriction and "cannot afford to pay" oath would not apply to him, and he would be entitled to home-town as well as hospital care. Rep. Henderson (R., Ohio) proposes a three-year "presumptive" period of service-connection for arthritis, psychoses and multiple sclerosis, as well as tuberculosis. The presumptive period for arthritis is now one year, for psychosis and multiple sclerosis, two years. The bill is H.R. 1143.—*AMA Washington Letter.*

* * *

Rise of Medical Care Costs.—The January issue of *Economic Indicators,* a statistical report published monthly by Joint Congressional Economic Committee, contains a table on consumer prices which puts medical care in a unique light. For it disclsoses that the cost index for this category (including hospitalization and drugs, as well as medical services) has gone upward without interruption since 1939—a distinction that cannot be claimed by housing, food, recreation, transportation or any other consumer item. Still the increase in medical care costs between 1939 and November, 1956, is not as great per percentagewise as the price rise for food, apparel, transportation or personal care, in the same span of years.—WRMS, 1-21-57.

* * *

The Henry Ford Hospital Medical Bulletin is published quarterly and contains papers written by the Professional Staff. It contains in abstract form the medical, surgical, and research papers published from The Henry Ford Hospital and from The Edsel B.

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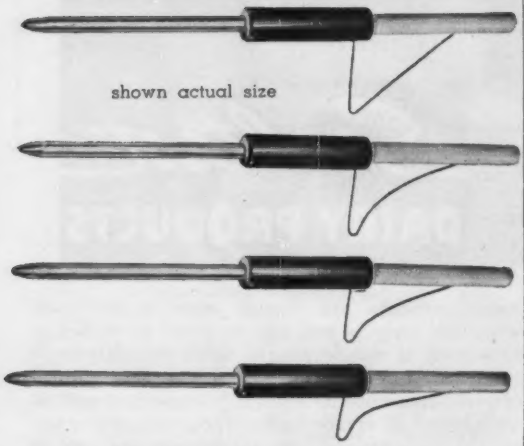

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* * *

The American Academy of Plastic Surgery for Head and Neck announces a Convention in Otolaryngologic Plastic Surgery conducted by Samuel Fomon, M.D., New York City, N. Y., to be held May 12, 1957 through May 18, 1957. Further information may be obtained by writing to Secretary, American Academy of Plastic Surgery, Manhattan General Hospital, 307 Second Avenue, New York 3, N. Y.

* * *

Fifty-nine unclassified life science research contracts in the fields of medicine, biology, biophysics and radiation instrumentation have been announced by the Atomic Energy Commission, as part of its continuing policy of assisting and fostering research and development in fields related to atomic energy. One of these awards has been made to the University of Michigan, the investigator being A. B. French. The subject of the research is "Effect of Irradiation on the Pituitary Adrenal Axis."

* * *

Fourth International Poliomyelitis Conference.—The Governments are being invited to send delegates to the Fourth International Poliomyelitis Conference to be held in Geneva, Switzerland, on July 8-12, 1957. Thomas Francis, Jr., M.D., Ann Arbor, is serving on the Scientific Program Committee.

* * *

Clinoptikons.—The Schering Corporation has presented THE JOURNAL with two Clinoptikons—one on common rheumatic disorders and the other on arthritis. The publication of these booklets, the first in a series, marks the beginning of a new Schering service to the medical profession.

The Clinoptikons depict anatomic and pathologic aspects of major diseases frequently encountered in medical practice. The full color medical drawings will help the physician to explain to the patient the nature of his condition. This will prove valuable to the physician in giving to the patient a fuller understanding of his condition and the procedures used to help him.

* * *

Polio Research.—The University of Michigan School of Public Health has received a grant from the National Foundation for Infantile Paralysis of $153,770, to attempt to find a chemical compound which can block the paralytic effects of polio. The research team working on this project is headed by Thomas Francis, Jr., M.D. His associates will include Drs. Gordon C. Brown, Wilber W. Ackerman, Kenneth W. Cochran, Jr., Donald E. Craig, R. Bernal Johnson and Richard E. Hartman.

This group has been studying the polio inhibiting effects of many chemical compounds with some promising experimental results.

Symposiums on three officially selected subjects will be a leading feature of the program of the Fourth Interim Congress of the Pan American Association of Ophthalmology, which is to be held in New York City, April 7-10, in joint session with the National Society for the Prevention of Blindness. Official subjects of discussion are (1) Diseases of the ocular fundus, (2) Ophthalmic surgery, and (3) Therapeutics in Present-Day Ophthalmology.

* * *

Two new Ciba publications, *State of Mind* and *Pulse and Pressure,* are now being distributed to physicians, beginning the first of the year, according to T. F. Haines, president of Ciba Pharmaceutical Products, Inc.

State of Mind is a monthly review of emotional and psychiatric problems, while *Pulse and Pressure* will report each month on current views concerning hypertension and related cardiovascular disorders. Both publications are designed for the general practitioner.

The objective of *State of Mind* is to cast some light on the various mental or emotional disorders which the general physician may be called on to treat, by providing a new medium of information and expert opinion.

Pulse and Pressure will serve the general practitioner as a medium for the opinions of leading cardiologists and other specialists in heart disease.

* * *

Alfred Whittaker, M.D., Honored.—On January 29, 1957, in its list of honorary degrees, included a Doctor of Arts degree for Alfred H. Whittaker, M.D., of Detroit. His citation is as follows:

ALFRED HEACOCK WHITTAKER

Alfred Heacock Whittaker, a native of Ohio; a graduate of the Ohio State University College of Medicine in 1918, for more than thirty years he has been engaged in the practice of General Surgery, with special interest in Industrial Medicine and Surgery.

His true physician's concern for the arts of healing has been exemplified and extended to problems of civic scope. To the Committees and Commissions on City Planning, Health, Housing, Libraries, and Urban Rehabilitation, he has given vigorous and inspiring leadership. His strong sense of human relationships has motivated his lifelong interest in our historical societies whose developing work he has supported by splendid contributions of time energy and money.

We have been privileged to share in his vision of a better community a vision which he has actively helped us in the present to shape closer to the best historic dreams and plans of the past.

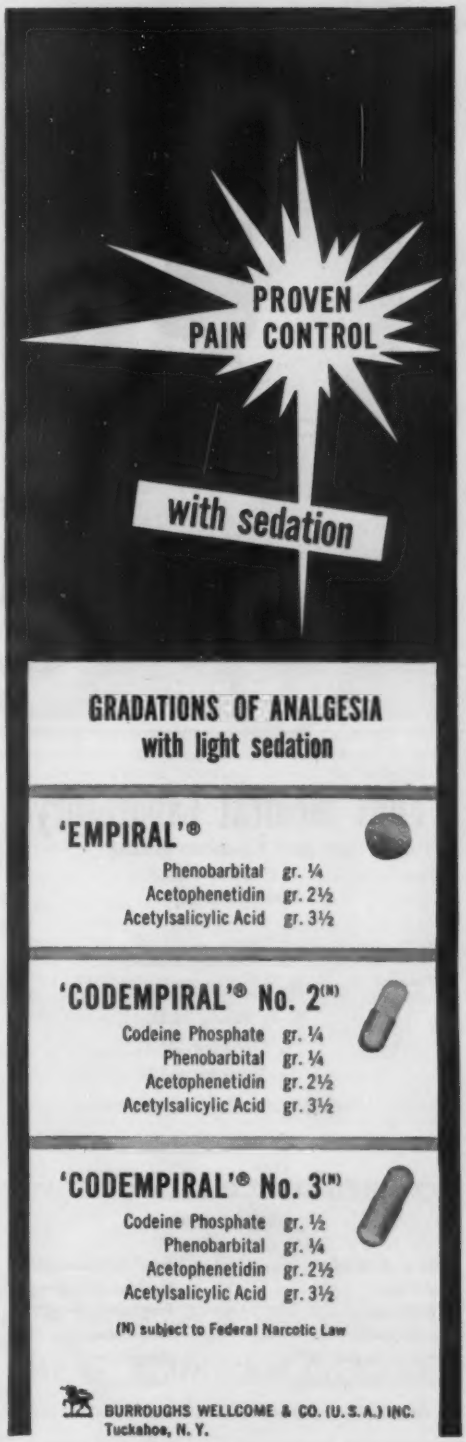
DOCTOR OF ARTS

* * *

The W. K. Kellogg Foundation has made a $401,515 commitment to the University of Pennsylvania School of Medicine for testing and improving the periodic health examination as an instrument for the early detection of disease and the promotion of health.—*Philadelphia Medicine,* February 1, 1957.

* * *

The second volume of the recently resumed series of annual reports of The Surgeon General, titled "Medical Statistics of the United States Army, 1954," has been recently published and is now being distributed.



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This report presents detailed statistics on the incidence of disease and injury, mortality, hospitalization, medical resources and similar subjects dealing with the health of Army troops. The volume is intended primarily for use by Army personnel directly concerned with the work of providing medical care. A limited number of copies are available for distribution to other military and civilian workers in the health field who have need for data of this kind. Any requests should be addressed to the Office of The Surgeon General, Attn: MEDCS.

* * *

American Board of Obstetrics and Gynecology.—The next scheduled Examinations (Part II) oral and clinical for all candidates will be conducted at the Edgewater Beach Hotel, Chicago, Illinois, by the entire Board from May 16 through 25, 1957. Formal notice of the exact time of each candidate's examination will be sent him in advance of the examination dates.

Candidates who participated in the Part I examinations will be notified of their eligibility for the Part II examinations as soon as possible.

* * *

The Ninth Annual Convention of the International Academy of Proctology will meet at the Plaza, New York, April 29, 30, and May 1, 2, 1957. Cocktails and dinner will be served the delegates and trustees and their wives, Sunday evening, April 28. All physicians are invited to attend the various functions, including the banquet, Thursday evening, May 2. Members and non-members are welcome to the convention. There are no fees for attendance.

* * *

Pharmaceutical Progress.—If a 1947 graduate of The University of Michigan College of Pharmacy were to enroll for his training all over again in 1957, he would not find any courses in pharmacy the same as those he took ten years ago, either in name or content.

According to Dean Tom D. Rowe of the College of Pharmacy, the reason for this startling change is the tremendous advance in the field of drugs. "More than 50 per cent of the drugs used today were not known ten years ago," he explains. "The job of keeping up with developments of new drugs and other new products, having to know and be familiar with them, gives the pharmacist one of the greatest 'continuing education' responsibilities of any professional man."

* * *

Interim Congress.—A special invitation is extended to Michigan physicians to attend the Fourth Interim Congress of the Pan American Association of Ophthalmology, which will be a joint session with the National Society for the Prevention of Blindness in New York City, April 7-10, 1957. Headquarters will be at the Hotel Statler.

* * *

Peter B. Rastello, M.D., has been appointed medical director of the Fisher Body Division of General Motors to succeed A. F. Lecklider, M.D., who retired in January after thirty-four years with Fisher Body. Dr. Rastello was born in Hancock, Michigan, and is a graduate of the University of Michigan Medical School.

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R. L. Novy, M.D., Detroit, was honored January 22 for sixteen years of outstanding service to Detroit, contributed as a member of the Detroit Board of Health. The tribute was made to Dr. Novy at a luncheon given by the Woman's Advertising Club in the Ford Auditorium.

Congratulations, Dr. Novy, on a magnificent job in behalf of the City of Detroit and the health of its people!

* * *

The Summer Camp for Diabetic Children will be opened for the eighth season under the auspices of the Chicago Diabetes Association, Inc., from July 14 to August 4, 1957, at Holiday Home, Lake Geneva, Wisconsin.

In addition to the complete camp personnel, the Chicago Diabetes Association furnishes a staff of resident physicians and dietitians, trained in the care of diabetic children.

Boys and girls, aged eight through fourteen years, are eligible. For further information regarding fees, interested persons should be directed to write or telephone the office of the Chicago Diabetes Association. Fees will be set on a sliding scale to meet individual circumstances.

Physicians are urged to notify parents of diabetic children and to enter the names of children who would like to attend camp. Applications may be obtained from and inquiries should be addressed to: James B. Hurd, M.D., Chairman, c/o The Chicago Diabetes Association, 5 South Wabash Avenue, Chicago 3, Illinois. ANdover 3-1861.

* * *

The Third Annual Nutrition Conference, sponsored by Wayne State University College of Medicine, will be held on Thursday and Friday, April 4 and 5, 1957. Speakers on the general subjects, "Fats—Helpful or Harmful," will include Drs. John B. Brown, Ohio State University; Frederick J. Stare, Harvard University; Grace A. Goldsmith, Tulane University; and Ancel Keys, University of Minnesota. Further information may be obtained by writing the Department of Physiological Chemistry, Wayne State University College of Medicine, Detroit 7, Michigan. All members of the Michigan State Medical Society are cordially invited to attend this conference.

* * *

It would appear that there are well authenticated instances where malnutrition was the only probable cause of a rise in tuberculosis morbidity and mortality, though in most instances it is one of several associated possible causes. There are also indications that malnutrition becomes operative as an etiological factor in tuberculosis only when a critical level is reached. On the other hand, it is recognized that optimum nutrition gives no absolute protection against tuberculosis, if other circumstances are unfavorable.—Alton S. Pope, M.D., and John E. Gordon, M.D., American Journal of Medical Sciences, September, 1955.

* * *

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*Martin, G.M., and Herrick, J. F.: Further Evaluation of Heating by Microwave and by Infra-red as Used Clinically, J.A.M.A. 159:1286 (Nov. 26) 1955.

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Treatment," a new medical film, is now available from the Medical Film Center of Smith, Kline & French Laboratories. Particularly oriented towards the physician in general practice, it also is suitable for medical teaching.

A 16 mm. sound motion picture in full color, the 25-minute film reviews the processes of metabolism and describes the etiology and diagnosis of hypometabolism, whether due to subnormal activity of the thyroid gland itself (hypothyroidism) or faulty cellular utilization of the thyroid hormone (metabolic insufficiency). The clinical use of "Cytomel," a new Smith, Kline & French Laboratories preparation designed for use in the treatment of hypometabolic states, is demonstrated in the film.

Prints of this film, as well as other medical motion pictures, are available on free loan to physicians and medical groups through SKF professional Service Representatives, or by writing: Medical Film Center, Smith, Kline & French Laboratories, Philadelphia 1, Pa. Four weeks' notice and an alternate showing date should be given whenever possible.

* * *

"The Pennsylvania State Medical Society's 201-member House of Delegates has unanimously voted to void and terminate its nine-month-old UMW Welfare and Retirement Fund agreement. Last May, the AMA pointed out that the agreement might help improve union-physician relations.

"Earlier, members of the medical staff at Citizens General Hospital, New Kensington, Pa., charged that the hospital had been boycotted by the union for refusing to accept UMW-sponsored physicians. This, said state society delegates, constituted a "plot" to "pack" the medical staff and seize control of the hospital.

"The delegates further contended that since October 1, the UMW has refused to pay bills incurred by beneficaries for non-emergency care and treatment at the New Kensington hospital. Dr. Warren F. Draper, outspoken medical director of the $52 million fund, declared that his organization feels "no obligation" to purchase medical services from any hospital.

"The evidence indicates that unless the UMW can control hospital staff appointments, it doesn't want to play."—AAGP Secretary's Letter, January, 1957, GP.

* * *

The Cook County Graduate School of Medicine announces an intensive course in Neuromuscular Diseases of Children with special emphasis on cerebral palsy, to be given by Meyer A. Perlstein, M.D., for the two-week period from July 8 to 19, 1957. This is an intensive, didactic and clinical course designed for pediatricians, orthopedists, neurologists, psychiatrists and physiatrists interested in the care and treatment of children with neuromuscular handicaps. Emphasis will be placed on the practical clinical aspects of treatment and rehabilitation procedures.

The course will include itinerant clinics to round out the program in most of its practical aspects. The fee for the course, which is $250, will include the cost of luncheons during the two-week period, as well as the

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expense of travel, meals and accommodations during the trip to the field clinic. For further information, write to John W. Neal, Registrar, Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois.

* * *

"Federal Income Tax Liability of Physicians" is a thirty-eight page booklet available from the AMA Law Department. It contains many matters of interest to physicians in preparing their 1957 income tax returns: business entertainment expenses, deductions for expenses incurred in taking postgraduate courses, and deductions for maintaining an office at home. For a copy of this booklet write Law Department, AMA, 535 N. Dearborn Street, Chicago 10.

* * *

Hungarian Physicians.—M. Arthur Cline, M.D., Executive Secretary of the American Medical Society in Vienna, writes that over 600 native Hungarian refugee doctors of medicine have been receiving the aid of the AMA of Vienna. Dr. Cline writes: "There are presently over 450 Hungarian doctors in Austria who wish to return to their practice as soon as a change in the Hungarian political situation permits. In fact, we are urging these colleagues to remain here (in Vienna) attending this possibility, for we feel that most of them, should they ever enter the United States, would encounter considerable difficulty with language and state board requirements. However, to maintain them here will require our further financial support for several months to come." Funds to aid these Hungarian doctors may be sent direct to Dr. Cline in care of 11 Universitatsstrasse, Vienna 1, Austria.

* * *

The first annual meeting of the **American Association of Medical Assistants** was held in Milwaukee October 26-28, 1956. Miss Hallie Cummins, Caro, Michigan, was elected as a member of the new Board of Directors; subsequently, the directors selected Miss Cummins as Chairman of the Executive Committee.

MSMS was represented by R. W. Shook, M.D., Kalamazoo, a member of the MSMS Council. J. E. Manning, M.D., Saginaw, was speaker at the banquet on "The Doctor's Dream Girl."

* * *

The Michigan Cancer Coordinating Committee's officers for the year 1957 are: Chairman, Harry M. Nelson, M.D., Detroit; vice chairman, James W. Hubly, M.D., Battle Creek; and secretary, William J. Burns, LL.B., Lansing. A vote of thanks was placed on the record to C. Allen Payne, M.D., Grand Rapids, for his efficient chairmanship of the MCCC during the past four years.

* * *

Alfred H. Whittaker, M.D., Detroit, received the honorary degree of Doctor of Arts from Wayne State University at its commencement exercises, January 29. Congratulations, Dr. Whittaker.

* * *

Wayne State University College of Medicine Alumni Clinic Day and Alumni Reunion will be held May 1, 1957, at the Fort Shelby Hotel, Detroit. Presentations will include "Returning the Cardiac to Work" by Herman K. Hellerstein, M.D., Cleveland; "Clinical Evi-

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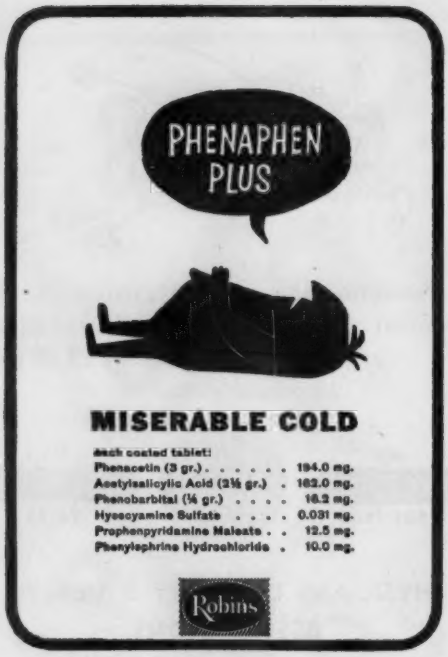

dences of Placental Deficiency" by Clyde L. Randall, M.D., Buffalo; "Diagnosis and Treatment of Surgical Lesions of the Stomach" by Campbell M. Gardner, M.D., Montreal; "Application of Psychiatry in General Practice" by R. W. Waggoner, M.D., Ann Arbor; "Emergency Surgery in the New Born" by William L. Riker, M.D., Chicago; and "Low-Grade Infections of the Urinary Tract" by Maurice A. Schnitken, M.D., Toledo. The scientific meeting will be followed by a reception and the annual banquet (Crystal Ballroom and Coral Room).

* * *

The American Medical Education Foundation completed its fifth year of operation with a record total of $1,072,717 in contributions—a 41 per cent increase over last year's total. Grants are being made to the nation's eighty-three medical schools.

* * *

$75,000 in Educational Policies.—In a contest which closes May 4, 1957, Johnson & Johnson, in co-operation with the Mutual Benefit Life Insurance Company, will offer educational policies totaling $75,000 through the Annual Youth Scholarship Fund. The contest will award scholarship prizes for the best fifty-word essays that complete the statement: "A Good Education is important because . . ." Top prize will be $10,000, with two prizes of $5,000, six fourth prizes of $1,500 each and thirty-six prizes of $1,000 each.

* * *

World Health Day is April 7—selected by the World Health Organization, according to Leroy E. Burney, M.D., Surgeon General of the Public Health Service.

L. G. Christian, M.D., of Lansing was given the first honorary lifetime appointment to a State commission—the first in the history of Michigan—when Governor G. Mennen Williams gave him this signal honor on January 24 in recognition of his long service on the Michigan Social Welfare Commission. Dr. Christian served on this Commission from the time it was first established in 1939 until October 15, 1956. The Governor, in making the honorary appointment, stated Dr. Christian exemplified "diligence, integrity, compassion and a love for all mankind, and that his public service brought not only great credit upon himself but great benefit to the people of Michigan."

* * *

The Upper Peninsula Medical Society's Sixty-Fourth Annual Meeting will be held June 21-22 in Houghton, Michigan, under the chairmanship of T. P. Wickliffe, M.D., Calumet, and Forrest W. Larson, M.D., Houghton, who will serve as secretary. Four excellent facilities will be used by the UPMS for its functions: the Douglass House, the Scott Hotel, the Onigaming Yacht Club, and the Memorial Union Building of Michigan Tech.

* * *

The Bahamas branch of the British Medical Association invites all MSMS members to attend its Bahamas Medical Conference in Nassau April 23-30, 1957, at the British Colonial Hotel and the Princess Margaret Hospital in Nassau. For information and program write to B. L. Frank, M.D., P.O. Box 148, British Colonial Hotel, Nassau.

* * *

The National Industrial Health Conference will be held at St. Louis April 20-26. For information write the Secretary of the Conference, 604 N. Michigan Avenue, Chicago 11, Illinois.

* * *

The University of Cincinnati's Institute of Industrial Health offers graduate fellowships in Industrial Medicine, providing professional training for graduates of approved medical schools who have completed one year of internship. This three-year course of instruction includes stipends for the first two years of between $3,000 and $4,000, depending upon marital status. For information write Cincinnati College of Medicine, Eden and Bethesda Avenues, Cincinnati 19, Ohio.

* * *

"Pediatric Advances for Pediatricians and General Practitioners" is the title of a short refresher course conducted by the staff of Children's Hospital, Philadelphia, May 27-31. Tuition $110.00. "Practical Pediatric Hematology" course will be held June 3-5—tuition $75.00; and "Blood Group Incompatibilities and Erythroblastosis Fetalis" on June 6-7—tuition $50.00. Inquiries should be addressed to Irving J. Wolman, M.D., 1740 Bainbridge Street, Philadelphia 46, Pennsylvania.

"Medicine—A Life Long Study" will be the theme of the Second World Conference on Medical Education to be held in Chicago August 30-September 4, 1959, under the sponsorship of the World Medical Association.

* * *

Labor Says:

Better Health Plans are a labor goal. At the last annual meeting of the American Public Health Association James Brindle, director of the United Auto Workers' Social Security Department, noted that although labor unions differ on details of how medical care ought to be provided and financed, most of them have supported legislation to establish a national health insurance program.

Since Congress has not enacted this legislation all unions, because of their health and welfare funds gained through collective bargaining, have the task of making the best use of the dollars set aside for medical care. Labor has used these dollars to purchase mostly hospitalization coverage and surgical benefits from Blue Cross, Blue Shield and commercial carriers. Some plans include home and office care but these are rare. In about fifty instances labor groups have established direct service medical centers where services are actually provided rather than cash indemnities to cover part of the costs.

The latter type of plan has proven more popular with members because there are no barriers to the service, preventive services are usually included in the benefits and there are no hidden bills cropping up after the services are rendered.

Health insurance in the last 20 years has had a phenomenal growth, mostly as a result of collective bargaining. Unfortunately, even at this date, the extent to which commonly available insurance programs meet a family's health needs is not too impressive to labor. Among the cause for difficulties is the system of indemnity payments for physicians' services which is not a satisfactory method of paying for services and are a base upon which some physicians too frequently add substantial charges. Also the emphasis on hospitalization and surgical coverage as in the case of most plans without substantial outpatient benefits is frequently a cause for unnecessary hospitalization. Also as a result of inadequate concern for operating efficiency in hospitals and an unwillingness to enforce legitimate controls there are unjustified premium increases.

Labor is beginning to focus more on the following objectives:

1. Complete prepayment for medical care without co-insurance and deductible features and hidden added costs.

2. Comprehensive benefits—only if the range of health services is complete will the individual's health needs be effectively and economically met.

3. Rational organization of medical services—on the basis of group practice, and

4. Control of the quality of medical services which must be built into medical care plans. (Dr. Morris Brand in *AFL-CIO News*, December 22, 1956.)

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Incompletely treated tuberculosis patients who leave sanatoriums and interrupt their drug therapy threaten the effectiveness of modern drug treatment for tuberculosis. These uncooperative patients may spread the disease in a form resistant to drug treatment.

At Maybury Sanatorium in Northville between 140 and 150 children are admitted annually. Dr. W. Leonard Howard, medical superintendent of the sanatorium, reported 31 per cent of the children admitted in 1955 were resistant to the modern drugs. Lowered death rates cannot be maintained if large numbers of patients enter sanatoriums with their tuberculosis resistant to life-saving drugs.

* * *

British Medics Fight for More Pay.—Average $4,875; Want $616 More from State: Britain's physicians were reported to have accumulated a fund to fight their demand for more money from socialized medicine. They held meetings over the week end to decide whether to stage a walkout on the health service.

Britain has nearly 40,000 doctors. All except 700 take part in the national health program. Some of the government physicians also take private patients but the number of Britons paying their own doctor bills is less than a million.

The government admits that doctors, under socialized medicine, today do not have the living standards of doctors under private medicine in 1939. But the government puts this down to demotion of doctors, as one report puts it, from the class of squire to that of civil servant. (Chicago Daily Tribune, 12-31-56.)—*Insurance Economics Surveys,* January, 1957.

M.D. LOCATIONS

Through February 1, 1957

Placed by Michigan Health Council	*Opened Practice*
Alvin Ratzlaff, M.D.	Berrien Springs
Floyd R. Town, M.D.	Hillman
C. E. Payne, M.D.	Ann Arbor
Assisted by Michigan Health Council	
P. G. Seven, M.D.	Flint
Don R. Morrill, M.D.	Holt

MEDICAL TELEVISION SHOWS

Produced by Michigan Health Council

Date	Station	Subject	Guests
Jan. 6	WJBK-TV, Detroit	Mickey's Miracle	Film
Jan. 13	WJBK-TV, Detroit	Tenth Annual Michigan Rural Health Conference	J. K. Altland, M.D., Lansing S. E. Chapin, M.D., Dearborn E. H. Wiard, Lansing
Jan. 17	*WKAR-TV, East Lansing*	Tenth Annual Michigan Rural Health Conference	Edward Kiley, East Lansing Dr. Frank W. Suggitt, Lansing Bob Starring, East Lansing Dr. Louis Wolfanger, East Lansing Fred Kellow, Lansing Carol Avery, Okemos Jim Kreider, Okemos Mary Madzia, Okemos Ted Warner, Okemos
Jan. 20	WJBK-TV, Detroit	Mental Health	Film—"Roots of Happiness"
Jan. 27	WJBK-TV, Detroit	Fire Safety	Film—"Farm Petroleum Safety"
Jan. 31	*WKAR-TV, East Lansing*	The Doctor Examines Your Heart	E. A. Irvin, M.D., Detroit John G. Bielawski, M.D., Detroit Ernest T. Guy, Detroit E. H. Wiard, Lansing

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THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

A MAN AGAINST INSANITY. By Paul de Kruif, Ph.D. 240 pages. New York: Harcourt, Brace & Co., 1957. Price: $3.95.

Has Michigan a modern Beaumont in its boundaries? Paul de Kruif answers that question with a sturdy "Yes" in his latest and most thrilling and emphatic book.

Beaumont's resounding research of the 1820's opened windows of knowledge about physiology of digestion; the modern pioneer, who becomes the modest hero of de Kruif's 1957 opus, whips chronic mental illness and gives promise not alone to abolishing mental institutions (and changing them into community treatment centers for abnormal behavior) but to guiding the more important road of *prevention*.

John T. Ferguson, M.D., of Traverse City State Hospital, is the central figure in "A Man Against Insanity." A zealous lone wolf, like William Beaumont, M.D., Dr. Ferguson has developed the plain science that insanity is too often just chemical imbalance that can be brought on an even keel by the use of certain modern behavior medicines (chemicals).

The greatest pull in the book is the sanguine hope for mental disease *prevention* through the work of the family physician:

"The family doctor is the father of psychiatry. It is this man who sees mental illness start. He practices soft shoe psychiatry with over half of his patients every day. And the public wants its competent modern general practitioners to handle its family mental and emotional problems."

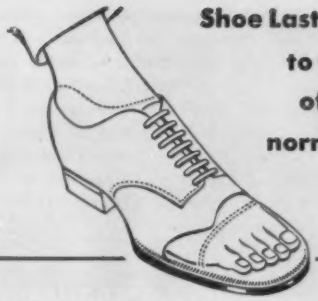
Hope for the cure and eventual *prevention* of insanity pervades this well authenticated document. Scientific facts abound—but never at the expense of reader interest. de Kruif's words rush with vigor and intensity and always with good humor and homey Americanisms —characteristics that make his labors "best sellers."

"A Man Against Insanity" has twelve chapters and 240 pages that can be enjoyed by physician and layman alike. The bright vision enfolded in the final thirty pages is "must" reading for all general practitioners.

W.J.B.

RECOMMENDATIONS FOR DRIVER LICENSING AND RE-EXAMINATION. PROPOSED AT SYMPOSIUM ON MEDICAL ASPECTS OF MOTOR VEHICLE ACCIDENT PREVENTION Center for Safety Education, New York University, Washington Square, New York. Reprints at $.50 per copy, in quantities of ten or more, $.40 each.

New driver licensing requirements have been proposed by 125 leading medical specialists from the United States and Canada and traffic safety authorities in government and industry, who met at New York University, May 23, 1956, for an all-day workshop conference on Medical Aspects of Motor Vehicle Accident Prevention.



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These recommendations, together with an anaylsis of research needs, are contained in the thirty-two-page report of the proceedings, contained in full in the December 15 issue of the *New York State Journal of Medicine*.

Co-sponsored by the University's Center for Safety Education and the NYU-Bellevue Medical Center, this pioneer conference was held in co-operation with the New York Academy of Medicine's Committee on Public Health, the New York Industrial Medical Society, and several county medical societies.

SICK CHILDREN. Diagnosis and Treatment. By Donald Paterson, M.D. (Edin.), F.R.C.P. (Lond.), F.R.C.P. (Canada), Consulting Physician to the Hospital for Sick Childern, Great Ormond Street, London; Consulting Paediatrician, Westminster Hospital, London; Honorary Consultant to the Department of Paediatrics at the Vancouver General Hospital; Sometime Clinical Professor of Paediatrics, Faculty of Medicine, University of British Columbia and Senior in Paediatrics, Vancouver General Hospital. Revised by Reginald Lightwood, M.D. (Lond.), F.R.C.P. (Lond.) D.P.H. (Eng.), Director, Paediatric Unit, St. Mary's Hospital Medical School, University of London, and Physician-in-Charge, Children's Department, St. Mary's Hospital, London; Physician to The Hospital for Sick Children, Great Ormond Street, London; Paediatrician to the Research Unit for Juvenile Rheumatism, Canadian Red Cross Memorial Hospital, Taplow; External Examiner in Paediatrics to the University of Wales. With the assistance of F. S. W. Brimblecombe, M.D. (Lond.), M.R.C.P. (Lond.), D.C.H., Paediatrician, Royal Devon and Exeter Hospital, and Exeter City Hospital; Consultant Paediatrician, Exeter Clinical Area. Philadelphia, Montreal: J. B. Lippincott Company. Price $8.75.

This is a very good book considering it has been written to cover the commoner children's diseases without being too detailed. It is concise, but yet covers enough to give a most adequate picture of any subject being quite complete regarding diagnosis and treatment. Reading the subject matter is very easy and interesting because of the manner in which the British authors present it. Due to this being a British text there are some variations and differences occasionally noted in either type of therapy or agents used. The publisher has unfortunately bound the book with the index pages not in order or sequence.

J.L.

ALLERGIC DERMATOSES DUE TO PHYSICAL AGENTS. Edited by Rudolf L. Baer, M.D., Associate Professor of Clinical Dermatology and Syphilology, New York University Postgraduate Medical School. 101 pages. New York University Press. Philadelphia and Montreal: J. B. Lippincott Company (distributors). Price: $3.00.

This is a small book of 101 pages which is an outline of the present knowledge of this somewhat limited field of Dermatology. The six contributors, who are well qualified in this field, have done a good job of presenting a subject which is still theoretical to a great extent. For those interested in these peculiar phenomena which occur on the skin, this book is a good summary and guide.

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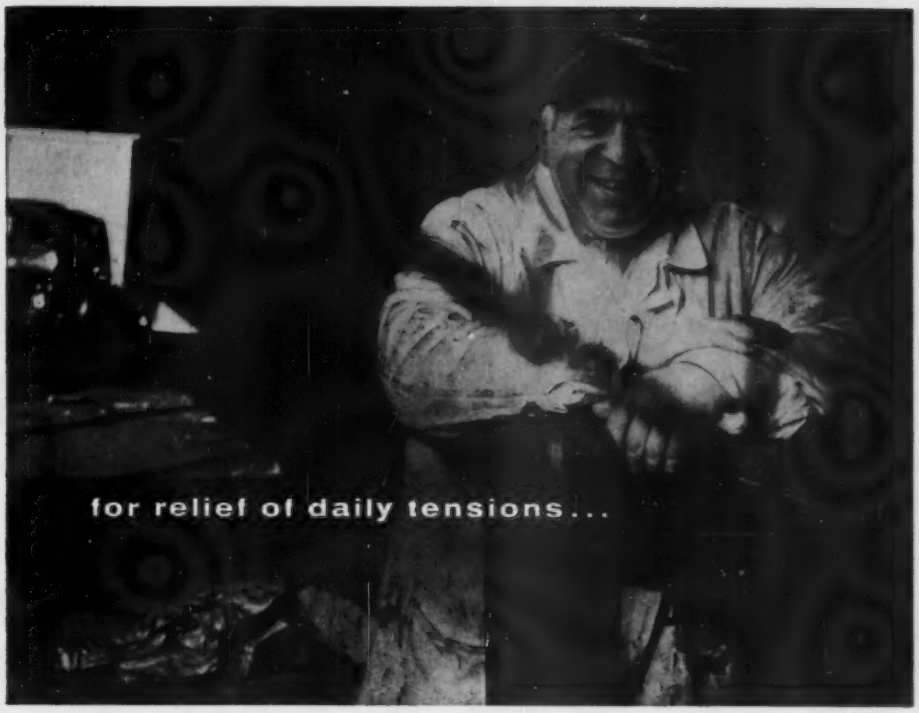

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*Ferguson, J. T.: J. Am. Geriatrics Soc. *4*:1080, 1956.

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